

**BEFORE THE  
MEDICAL BOARD OF CALIFORNIA  
DEPARTMENT OF CONSUMER AFFAIRS  
STATE OF CALIFORNIA**

**In the Matter of the First Amended Accusation against:**

**DAVID JAMES SMITH, Respondent**

**Case No. 800-2015-013651**

**OAH No. 2018080617**

**DECISION AFTER SUPERIOR  
COURT REMAND**

Vallera J. Johnson, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter on September 16, 17, 18, 23, 24, 25, 26, 27, and October 2, and 3, 2019, and January 3, and 30, 2020.

Joseph F. McKenna, III, Deputy Attorney General, represents the Executive Director of the Medical Board of California, (board) Department of Consumer Affairs.

From commencement of the hearing, Fenton Law Group, LLP, Henry R. Fenton and Summer A. Main, and Matthew D. Rifat, Attorney at Law, of the Law Offices of Matthew D. Rifat represented David James Smith, M.D.<sup>1</sup>

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<sup>1</sup> On January 3, 2020, Fenton Law Group, LLP, Henry R. Fenton and Summer A. Fenton Main filed a Withdrawal of Counsel in this matter. Michael D. Rifat, Attorney at

Oral and documentary evidence was received.<sup>2</sup> The record was closed, and the matter was submitted on April 15, 2020.

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Law, of the Law Offices of Matthew D. Rifat, continued to represent David J. Smith, M.D.

<sup>2</sup> On January 30, 2020, the taking of testimony concluded.

On February 19, 2020, a hearing occurred to address remaining issues, including exhibits and scheduling written closing argument. Respondent offered exhibits J (CDC Guideline for Prescribing Opioids for Chronic Pain - United States 2016); O (Treatment of Chronic Pain Conditions - a Comprehensive Handbook, Jason E. Pope and Timothy R. Deer, Editors); and W (Report of Lawrence R. Poree, M.D., M.P.H., Ph.D., dated April 23, 2018). During the hearing, respondent offered exhibits J and O to impeach the testimony of Dr. Pope. In addition, there were references to exhibit J by Dr. Pope and respondent during the hearing. There was no reference to exhibit O or W during the hearing. The motion to admit exhibits O and W was denied. The motion to admit exhibit J was granted.

In addition, on February 19, 2020, the administrative law judge set the schedule for filing closing arguments. Thereafter, each of the parties filed motions to extend the time to file closing argument. Without objection by the other party, the motions were granted. On March 12, 2020, complainant filed his closing argument, it was marked exhibit 96. On April 3, 2020, respondent filed his closing brief, and it was marked exhibit 97.

The Administrative Law Judge issued her Proposed Decision on June 25, 2020, finding Respondent committed gross negligence, repeated negligent acts and failed to maintain adequate records as to patients A, B, C, D, and E. The Proposed Decision was adopted by Panel B of the Medical Board of California on August 25, 2020.

On September 28, 2020, Smith filed his petition for writ of administrative mandate challenging the Board's decision. On November 3, 2021, a trial on the writ petition was heard by the Superior Court. Exercising its independent judgment on the evidence, on January 24, 2022, the Superior Court found an abuse of discretion in so far as the Administrative Law Judge excluded Respondent's expert testimony concerning patients A, C and D. Notwithstanding, the Court found that the weight of the evidence adduced at hearing supported the Board's findings on patients B and E and that the Board's Decision concerning patients B and E is not impacted by the Court's ruling concerning the erroneous exclusion of Respondent's expert witness testimony concerning patients A, C and D. The Court further found that the discipline imposed on Respondent in the Board's August 25, 2020, Decision was not a manifest abuse of discretion, and the penalty was not arbitrary or capricious. The Court granted the writ petition solely on the grounds that Respondent did not receive a fair trial with respect to patients A, C and D, and expressly stated the Board's discretion to decide this matter is not in any way limited or controlled by the Court's Order. Judgment was filed and served on February 28, 2022.

Having reviewed the record and Superior Court's order, and written and oral argument from the parties after remand, the Panel now makes and enters its decision after remand as follows:

## FACTUAL FINDINGS

### Jurisdictional Matters

1. Complainant filed Accusation and First Amended Accusation, Case No. 800-2015-013651 regarding respondent's care and treatment of five patients.<sup>3</sup> Respondent filed a timely Notice of Defense.

### Burden and Standard of Proof

Complainant bears the burden of proving the charges by clear and convincing evidence to a reasonable certainty. (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853.) This requires that he present evidence "of such convincing force that it demonstrates, in contrast to the opposing evidence, a high probability of the truth" of the charges (BAJI 2.62), and be "so clear as to leave no exhibit X. On April 15, 2020, complainant filed his closing rebuttal argument, and it was marked Exhibit 97.

On April 15, 2020, the record was closed, and the matter was submitted.

<sup>3</sup> The Accusation was filed on April 27, 2018, and the First Amended Accusation was filed on February 13, 2019. Pursuant to Business and Professions Code section 2203.5, the board must file the Accusation within three years after the board discovers the act or omission alleged as a ground for disciplinary action, or within seven years of the actual act or omission, whichever occurs first. Any facts alleged beyond the foregoing statute of limitations is for informational purpose only, not for disciplinary action.

Cal.App.3d 1189, 1208.) If the totality of the evidence serves only to raise concern, suspicion, conjecture or speculation, the standard is not met.

## **License History**

2. On August 21, 1989, the board issued Physician's and Surgeon's Certificate Number G66777 to respondent. The certificate is current, with no history of discipline, and will expire on January 31, 2021, unless disciplined or renewed.

## **Respondent's Education, Training and Experience**

3. Respondent provided evidence of his education, training and experience.

He obtained his Bachelor of Science degree in zoology from San Diego State University in 1983. He graduated from Northwestern University School of Medicine in 1988. Respondent completed an internship in internal medicine at the University of California Los Angeles (UCLA) Wadsworth Veterans Administration, and thereafter, a three-year residency program in physical medicine and rehabilitation, which encompassed several subspecialties including pain medicine; prosthetics for amputees (both upper and lower extremities, above and below knee, and above and below elbow); traumatic brain injury; stroke rehabilitation; pediatric aspects (cerebral palsy, birth defects and myelomeningocele defects); and sports medicine.

For more than 25 years, he has been a pain management practitioner, focused on interventional pain medicine, which he described as "the application of current outpatient surgical, and "minimal invasive techniques to ameliorate, reduce or eliminate chronic neuropathic pain."

Respondent is board certified in physical medicine and rehabilitation and in pain medicine.

Between 1993 and 2000, respondent trained under David Rutberg, M.D., a board-certified neurosurgeon, "where [he] first cut his teeth, so to speak," on neuromodulation, which involves epidural stimulation with electricity and intrathecal drug therapy. Also, respondent learned to do stem implants and pulp implants under Dr. Rutberg; in 1994, Dr. Rutberg and respondent did a pump trial implant. Over the past 25 years, respondent has implanted 600 to 700 intrathecal pumps<sup>4</sup>. With the exception of the foregoing, respondent offered no evidence to establish what the training involved and minimal evidence of Dr. Rutberg's qualifications to train him.

Respondent described the steps he has taken to keep current in his specialty. He has taken Medtronic (produces, among other things, intrathecal pain pumps)

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<sup>4</sup> An intrathecal pump is a medical device used to deliver medication directly into the space between the spinal cord and the protective sheath surrounding the spinal cord for targeted drug delivery. An intrathecal pump delivers medicine directly into the cerebrospinal fluid and requires a significantly smaller amount of medication compared to systematically taken (orally) medication due to bypassing the systematic path that oral medication must travel in the body. An intrathecal pump is a programmable, and it stores information about medication in its memory. An intrathecal pump is programmed to slowly release medication over a period of time and can be programmed to release different amounts of medication at different times of the day. When the intrathecal pump's reservoir is almost empty, the medication is refilled by insertion of a needle through the skin and into the fill port on top of the pump's reservoir.

training courses, and attended conferences and continuing medical education courses; in addition, he attended cadaver teaching/training courses where he learned new techniques. Also, he is a member of the societies in his specialty; he is a member of the American Pain Society; the American Society of Interventional Pain Physicians, and the American Academy of Pain Medicine. Until five years or so ago, he was a member of the American Association of Neuromuscular and Electrodagnostic Medicine. He is on staff at Scripps Mercy Hospital and Kindred Hospital and has served on medical executive committees of these hospitals.

Respondent has been active as a specialist in pain management. Until about 2008, he has lectured a number of times and co-presented with others, including Drug Enforcement Administration officers. During this same time frame, he has collaborated with intrathecal pump manufacturers.

### **Complainant's Expert Witness**

4. Jason Pope, M.D. (Dr. Pope) served as complainant's expert witness. He evaluated the care and treatment that respondent provided the five patients identified in the First Amended Accusation. In order to do so, among other things, he reviewed the complaint filed by Timothy Furnish, M.D. (Dr. Furnish), a physician who provided medical care for Patient A while she was a patient at University of California San Diego (UC San Diego Health), the medical records of each patient, and issued a report for each patient.

5. Dr. Pope provided evidence of his education, training and experience. He obtained a Bachelor of Science degree in chemistry in 2000 and graduated from Indiana University School of Medicine in 2004. He completed an internship and a

residency in anesthesiology at Vanderbilt University Medical Center in 2008. Dr. Pope completed a one-year pain management fellowship at Cleveland Clinic in 2010.

Dr. Pope has been licensed to practice medicine in California since 2010. In addition, he is licensed to practice medicine in West Virginia, Arizona, Virginia, Ohio, and Tennessee.

Dr. Pope has been board certified in anesthesiology since 2008 and in pain management since 2010.

Dr. Pope has presented at meetings of professional associations and societies made up of neurosurgeons, orthopedic surgeons, spine surgeons, psychiatrists, neurologists, anesthesiologists and urologists. He is a member of and held a variety of positions in his field, including California Society of Interventional Pain Physicians, American Academy of Pain and Neuro Science, International Neuromodulation Society, and North American Neuromodulation Society.

Dr. Pope's background in intrathecal therapy has been extensive. In summary, he testified about the papers/articles, leading journal publications and book editor contributions that he authored and which content was germane to the allegations in this case. Significantly, Dr. Pope has written extensively about and participated in the drafting of practice guides and "best practices" in the field of neuromodulation and intrathecal therapy to promote safety and long-term improvements in pain. He testified about his work as a clinical researcher for Food and Drug Administration regulated studies, including his current role as the national primary investigator for research dealing with intrathecal pump therapy.

For a year prior to completing his fellowship, Dr. Pope practiced as a pain management physician. After he finished his fellowship, Dr. Pope Practiced for six

months and then returned to California. He left in 2012 and returned to California in 2015. He described his current medical practice as a pain management specialist. For the past two and one-half years, he has been in a standalone practice in northern California. Depending on the week, his day-to-day practice consists of: (1) evaluating and consulting with new and existing patients, three to five half-days per week; (2) performing regional interventions, which include injections around different generators two to three half days a week; and (3) performing minimally invasive surgery two to three one-half days a week. He has hospital privileges at Healdsburg District Hospital, Sonoma Valley Hospital, Santa Rosa Memorial Hospital and Santa Rosa Sutter Hospital.

### **Credibility of Expert Witness and Respondent**

6. In determining the facts of this case, in addition to the burden of proof, the credibility of the expert witness and of respondent, who gave testimony as a percipient expert witness, have been considered.

Dr. Pope has practiced in California for less than three years. However, his academic training and involvement in pain management and interventional medicine is extensive. Notably, when provided with additional medical records, he changed some criticisms of respondent's practice. No evidence was offered to establish that he was not qualified to provide the opinions in this case. Dr. Pope was honest, candid and unbiased when he testified in this case.

Respondent obtained his training as an interventional pain management specialist from a neurosurgeon more than 25 years ago. Though he attended training, attended continuing education, participated in some organizations and made some presentations: respondent's formal academic training was minimal; his most recent

presentation was in 2008; his responses in this case were based on his experience with and knowledge of the patient, not the standard of care. He seemed to have no awareness that the standard of care changed over the years relevant in this preceding. In other words, in his opinion, his conduct was within the standard of care because there had been no complaint from other physicians who provided care and treatment for his patients, before Dr. Furnish; his medical records were sufficient because his records were better than some he had seen. He did not respond to the concerns for the patient posed by Dr. Pope. There is no evidence that respondent was anything but candid, but he cannot be considered unbiased.

For the foregoing reasons, despite his limited experience in California, Dr. Pope was more credible than respondent.

## **PREHEARING MOTIONS**

Prior to hearing, respondent filed a motion to exclude the opinion and testimony of complainant's expert witness because complainant failed to comply with requirements of Business and Professions Code section 2334. After considering documentary and oral arguments, the administrative law judge determined that complainant complied with Business and Professions Code section 2334; specifically, complainant filed the expert report in a timely manner and, therefore, respondent's motion was denied.

Prior to hearing, complainant filed a motion to exclude the opinion and testimony of respondent's expert witness because respondent failed to comply with the requirements of Business and Professions Code section 2334. After considering documentary and oral arguments, the administrative law judge determined that

respondent failed to comply with Business and Professions Code section 2334, subdivision (a)(2); the report of respondent's expert witness was deficient; it did not include: (1) a complete statement of each opinion the expert would express and the bases and reasons for each opinion; (2) the facts or data considered by the expert in forming the opinions; and (3) any exhibit used to summarize or support the opinions; and therefore granted the motion. Accordingly, respondent's expert was precluded from testifying in this hearing.

### **Patient A<sup>5</sup>**

7. On August 30, 2015, Dr. Furnish filed a complaint with the board regarding respondent's care and management of Patient A's implanted intrathecal pump.

The complaint filed by Dr. Furnish is discussed herein because Dr. Furnish testified; as the complainant's witness, and not as an expert, Dr. Furnish testified regarding what occurred during his care and treatment of Patient A in 2013 and 2015; in making determinations regarding technical issues described in the complaint, Dr. Pope's testimony and opinions were relied upon.

8. Since 2006, Dr. Furnish has been licensed by the board as a physician and surgeon. He is board certified in pain medicine and anesthesia. For the past nine years, he has been a physician on staff at the University of California - San Diego Medical Center (UC San Diego Medical Center); his practice is primarily outpatient chronic pain with a subset of inpatient complex acute pain. He sees patients with a variety of chronic pain conditions. He sees patients for whom he has been consulted; these

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<sup>5</sup> The letter is used to maintain patient confidentiality.

patients are in the hospital for some acute issue and also have difficult pain control issues. In his practice, he prescribes opiods for chronic pain. Since 2013 Dr. Furnish has had administrative responsibility for UC San Diego Medical Center's pain management fellowship program which includes recruitment, interviewing, and putting the educational program together.

9. During the summer of 2013, Patient A had a prolonged admission to UC San Diego Medical Center. She had an intrathecal pump that had been managed by respondent. During the hospital stay, she needed to have her pump refilled twice. Respondent could not fill Patient's A's pump because he did not have privileges to provide care at UC San Diego Medical Center.

Therefore, UC San Diego Medical Center's "pain service" did the pump refill. In 2013, Dr. Furnish had filled intrathecal pumps on a weekly basis for the prior six years. The first time that Patient A required a pump refill, Dr. Furnish interrogated the pump to determine the concentrations and doses that respondent programmed into the pump.<sup>6</sup> The pump's internal computer (similar to a medical record) listed the concentration of drugs, and the daily infusion dose of those drugs in milligrams, not

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<sup>6</sup> There is an external device that radio communicates with the pump. The pump records the information about when the pump was implanted, how long the battery has left to live, the concentration of various drugs inside the pump, the dose the pump is delivering on a daily basis, and when the pump gets close to empty. In order to refill the pump, the practitioner requires the foregoing information; the information is printed on a report or telemetry sheet and is similar to a prescription. As such, there is no need to contact the physician to get this information.

micrograms (mcg),<sup>7</sup> even though mcg is the standard measurement of concentration of medication used in the intrathecal pump.

Due to what Dr. Furnish characterized as, "extremely high doses", he called and spoke with respondent who verified the listed concentrations and infusion doses. Based on respondent's verification, the pharmacy prepared the refill drug, and Dr. Furnish refilled Patient A's intrathecal pump.

10. Again, in June 2015, Patient A was admitted to UC San Diego Medical Center and needed to have her intrathecal pump refilled during her stay.

During the June 2015 hospital stay, prior to refilling the pump, Dr. Furnish interrogated the pump. Because the concentrations and doses were "substantially higher than what was considered usual," he called respondent's office to verify the pump concentration and doses; He did not receive a response and left a message. A woman returned the call and identified herself as one of respondent's nurses. Dr. Furnish read the information that he obtained when he interrogated the pump - 25

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<sup>7</sup> There are 1,000 micrograms in one milligram.

mg/ml of Fentanyl<sup>8</sup>, 25 mg/ml of Hydromorphone {also known as Dilaudid<sup>9</sup>}, and 5 mg/ml of Bupivacaine, and delivering 18.49 mg/ml of Fentanyl/day. Initially the nurse in respondent's office verified the drug concentrations and doses and explained how the drugs were prepared, mixing different amounts of Fentanyl and Hydromorphone in the pump, which did not make sense to Dr. Furnish. After he asked a few questions, she offered to fax the "formula sheet."<sup>10</sup> After receiving the "formula sheet" from respondent's office, Dr. Furnish performed some calculations. He determined that the "formula sheet" indicated major discrepancies between its listed concentrations and dosages and the final concentrations in Patient A's pump. Dr. Pope and respondent confirmed the foregoing. The concentrations respondent listed in the intrathecal pump were concentrations of the ingredients before they were mixed together and not the

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<sup>8</sup> Pursuant to Health and Safety Code section 11055, subdivision (c), Fentanyl is a Schedule II controlled substance. Pursuant to Business and Professions Code section 4022, Fentanyl is a dangerous drug. Fentanyl is a potent synthetic opioid drug used as an analgesic and anesthetic. Fentanyl is "approximately 100 times more potent than morphine and 50 times more potent than heroin as an analgesic." (Drugs of Abuse, Drug Enforcement Administration (DEA) Resource Guide (2017 Edition), at p. 40.)

<sup>9</sup> Pursuant to Health and Safety Code section 11055, Dilaudid, a brand name for Hydromorphone, is a Schedule II controlled substance. Pursuant to Business and Professions Code section 4022, Dilaudid is a dangerous drug.

<sup>10</sup> The "formula sheet" is also known as the "excel sheet". Respondent explained that a former nurse who worked in his office and a "math teacher from San Diego State University or UCSD developed the excel sheet" in order "to reconcile the absolute rate per day of individual solutes in the pump."

final concentrations in the pump; the final concentrations of the drugs were actually lower.

Based on the "formula sheet" and his calculation, Dr. Furnish determined that the actual concentration of medications in the pump were 15 mg/ml Fentanyl, 7.5, mg/ml Hydromorphone, and .5 mg/ml Bupivacaine. Patient A was actually receiving 10.1 mg/day of Fentanyl, 5.55 mg/day of Hydromorphone, and .37 mg/day of Marcaine. Dr. Furnish refilled and reprogramed Patient A's pump based on the "formula sheet" and his calculation.

Towards the end of Patient A's hospital stay, Dr. Furnish faxed a note to respondent's office indicating that he had reprogramed the pump with the actual concentrations.

11. In 2013 when he refilled Patient A's pump, Dr. Furnish did not have the "formula sheet," and therefore, after personally confirming with respondent, Dr. Furnish refilled the pump based on the information respondent recorded in the pump's computer. Therefore Dr. Furnish filled the wrong concentrations

Dr. Furnish explained that the national standard of care for pumps is to list the actual concentrations and daily infusion doses being delivered by the pump, not the ingredient concentrations, as respondent did. Based on the foregoing, in 2013, Dr. Furnish was concerned about the care he provided Patient A because Dr. Furnish believed that respondent led Dr. Furnish to overdose Patient A's daily Fentanyl dose by 66 percent and the Hydromorphone dose by 233 percent.

12. Dr. Pope identified the records he reviewed and upon which he relied in rendering his opinions regarding respondent's care and treatment of Patient A, including the following:

- Online complaint,
- Medical records from UC San Diego Medical Center,
- Medical records from respondent's office and clinic for Patient A, dated January 6, 2010 through July 25, 2016,
- Respondent's curriculum vitae, continuing medical education, and opioid maintenance contract,
- Respondent's retention of medical records policy,
- Medtronic drug calculations and progress notes for Patient A, and
- Transcript of respondent's interview regarding Patient A.

13. Commencing 2006, respondent provided treatment for Patient A's chronic pain. Relevant to this proceeding was the treatment that he provided between May 2011 and 2017.<sup>11</sup> She had a variety of co-morbidities, including morbid obesity, lumbar spondylosis, lumbar radiculopathy, sleep apnea, knee osteoarthritis, chronic obstructive pulmonary disorder (COPD) and open wounds.

As early as 2006, respondent treated Patient A's pain with intrathecal pump therapy. In or around 2012 and 2013, respondent implanted new intrathecal pumps in Patient A due to various medical issues.

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<sup>11</sup> Conduct occurring more than seven years from the filing date of the Accusation (April 27, 2018) involving Patient A is for informational purposes only and is not alleged as a basis for disciplinary action.

14. Complainant alleged that, from October 2012 until 2017, respondent managed Patient A's pain through intrathecal drug therapy and "high dose" systemic {oral} opioid drug therapy.

Dr. Pope described "high doses of opioid drug therapy" as doses that exceed certain morphine equivalency {MME}<sup>12</sup> doses. He explained that to standardize or qualify how one opioid compares to another, morphine is designated as the base value of potency. Everything is compared to morphine. The conversion tables that have been created have been based on a clinical experience of one medicine versus the other. Because there are a lot of different opioids and because morphine is one of the most studied opiates, the purpose of MME calculations is to communicate the dose the patient is receiving in relationship to morphine. In the pain management practice, the MME allows the physician to appreciate how much opioid the patient is getting over a 24-hour period.

In 2013, the Center for Disease Control (CDC) recommended no more than 90 MME for non-cancer related pain; by 2017, though, the CDC recommendations are controversial, there was clear evidence that the higher the morphine dose equivalent per day is the higher the likelihood of overdose and death. "So [Patient A's oral] opioid regimen by itself, looking at the peer-reviewed literature that we have would suggest that this patient has a high likelihood of potentially overdosing and death as compared to someone on less oral opioid-based medicine." Also, Dr. Pope stated that,

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<sup>12</sup> Morphine equivalency is also known as modified morphine equivalent. The acronyms are MME, MED and MEq.

in 2016, "there was a clear understanding that if you were over 200 MME, the likelihood of overdose and death is markedly higher."

15. Though he acknowledged that he regularly prescribed opioids in excess of 300 MME for Patient A, respondent believed that he acted within the standard of care. However, he disputed that the dose was excessive. In his opinion, "he does not treat charts;" he treats patients on an individualized basis; he assesses his patients and customizes the treatment plan to the patient, his experience with the patient, his familiarity with the patient and the pharmacogenetics that the patient has displayed over many years. "This is how patients should be treated, not based upon a guideline that is pulled from a chart or a table and meant to be across the board." He utilized the foregoing criteria in justifying the opioids to Patient A.

16. Notwithstanding the intrathecal pump therapy, respondent routinely prescribed oral opioid medication that often exceeded 300 MME in a day. By 2017, for several years, respondent had not changed the prescribing of high dose opioids and intrathecal opioid therapy. Between October 2012 and 2017, respondent did not wean the systemic opioid medication after the intrathecal pump was placed nor during management of the pump. Patient A's co-morbidities, which included COPD, morbid obesity and sleep apnea, increased her risk of overdose and death.

17. It was established that, from October 2012 until 2017, respondent managed Patient A's pain through intrathecal drug therapy and "high dose" systemic (oral) opioid drug therapy.

18. During this same time frame, [when she was not hospitalized at UC San Diego Medical Center], respondent routinely filled Patient A's intrathecal pump with "massive doses" of controlled pain medication and routinely prescribed "excessive doses of systemic opioids" and other controlled substances. Respondent prescribed potent medications from the combined drug therapies (intrathecal and systemic) to Patient A at the same time.

19. On October 2, 2012, respondent implanted another intrathecal pump in Patient A. Seven days later, he filled and interrogated the pump. Respondent recorded the initiating dose of Fentanyl as 2.499 mg/day in Patient A's pump.

20. Dr. Pope testified that, even though Patient A had previously received intrathecal therapy with Fentanyl, on October 9, 2012, this was an "initiation" because it had been more than four weeks since Patient A had received intrathecal therapy; in fact, it had been 33 weeks. Because of the time between the ending of pump infusion to the beginning of the next, her body restored itself, to some degree, back to being opioid naive.

21. On October 9, 2012, respondent documented the initiating Fentanyl dose at a concentration of 25 mg/ml, and Marcaine 5 mg/ml, with a starting dose of 2.499 mg/ml of Fentanyl per day.

In Dr. Pope's opinion, this was an extremely high dose of Fentanyl. He explained that Fentanyl is 100 to 150 times more potent than Morphine. Fentanyl is recorded in micrograms, not milligrams; there are 1000 micrograms in one milligram. "The

recommendations from the Polyanalgesic Consensus Conference (PACC) of 2012 was 25 to 75 mcg per day [of Fentanyl] in an inpatient setting." As such, respondent intended that Patient A receive 2,499 mcg/day of Fentanyl. However, after accounting for dilution, Dr. Pope found that Patient A "received 2.241 mg/day, which equals 2,241 mcg as a starting dose as an outpatient." Dr. Pope also stated that the PACC of 2012 did not set a dose limit of the amount of Fentanyl that could be prescribed, "but most authors described that the maximal dose that you would get to after titration would be anywhere from 2,000 to 5,000 mcg per day." So, that was after titration over a length of time, not an initiating dose. Dr. Pope stated that he had never seen Fentanyl initiated over 2,000 mcg at an inpatient or outpatient setting.

Significantly, Dr. Pope found that respondent's intended initiating dose of intrathecal Fentanyl on October 9, 2012, was "the largest initiating dosing ... of Fentanyl into a patient" that he had seen.

22. Respondent did not dispute the facts in the foregoing paragraph. However, in respondent's opinion, the dose of Fentanyl was not excessive. He stated that, along with other variables (tolerance, body habitus, pharmacogenetics, amount of oral pills Patient A had taken) and Patient A's positive response at 2.4 or 2.5 mg/ml of Fentanyl caused respondent to "be secure and safe in initiating this as a starting dose." However, no evidence was offered to establish that Patient A had a pump trial during the 33 months prior to implantation and fill of the intrathecal pump in October 2012. Therefore, respondent's argument was rejected.

23. Between October 2012 and 2017, respondent routinely filled Patient A's intrathecal pump with "massive doses", as Dr. Pope put it, of controlled pain medication and routinely prescribed "excessive doses of systemic opioids" and other controlled substances. Respondent prescribed potent medications from the combined drug therapies (intrathecal and systemic) to Patient A at the same time.

24. Complainant alleged that respondent did not clearly and accurately document the concentration of initial medication that was used.

According to the chart note for October 9, 2012, respondent initiating Fentanyl dose was documented at a concentration of 25 milligrams (mg) per millimeter (ml), Marcaine 5 mg/ml, with a starting dose of 2.4999 mg of Fentanyl per day.

Complainant's expert testified that the standard of care is to accurately program the pump with concentrations within the solution. When respondent programmed the pump, he in-putted the initial concentrations of Fentanyl 25 mg/ml, Marcaine 5 mg/ml, and the daily dose as 2.499 mg/ml. However, the actual concentrations of the drugs in the pump were Fentanyl 22.6 mg/ml, Marcaine 0.4997 mg/ml with a daily dose of 2.241 mg/ml of Fentanyl.

Between October 2012 and 2017, during the time that respondent managed Patient A's intrathecal pump refills, there was inaccurate documentation in the pump interrogation report.

Significantly, Dr. Pope noted that, based on the review of Patient A's medical records, respondent made the same error consistently throughout the tenure of his care of Patient A; after the refill at UC San Diego Medical Center in July 2015 respondent reverted back to the "formula sheet" when he programmed Patient A's pump.

25. Respondent admitted that he did not clearly and accurately document the medication that was used in the pump. He described the protocol used to determine whether a pump might be beneficial for his patient, described the pump trial and stated that about 20 percent of his patients did not receive the intrathecal pump.

Respondent explained that, over the previous 25 years, he had implanted at least 600 pumps. He described the protocol that he used to determine whether an intrathecal pump might be beneficial for pain control for a patient; if the pump was the consideration, there was a pump trial; thereafter, about 20 percent of patients did not receive a pump; the intrathecal pump was implanted in an outpatient setting; he identified the medicines that he typically selected to be infused in the pump; he described the "formula sheet/excel sheet" that he developed to calculate the final concentration of medicines, the daily infusion rate and the pump telemetry sheet.

Unlike Dr. Pope (who got his medication from the compounding pharmacy already in a syringe), respondent ordered individual vials from the compounding pharmacy and mixed it at the time of the fill; this allowed him to be patient-specific, to talk to the patient at the time of the pump fill to determine if he needed to "implement any formula changes." Respondent stated that, over -20 years, this had morphed into how he had done it in order to provide the greatest amount of flexibility to the patients at the time of their presentation for fills.

Respondent has had patients in hospitals, skilled nursing facilities or moved from San Diego County who required pump refills, and he described the procedure he followed in such circumstances. When notified he had a patient in the hospital, respondent stated, typically, it was easier if he refilled the pump himself and was granted temporary hospital privileges to do so. If he was unable to fill the pump,

respondent or his staff forwarded the "excel sheet", telemetry sheet, also known as a "telesheet", (data from the pump) and the most recent chart note to the hospital, skilled nursing facility or accepting physician; at times, he received and responded to calls about pump refills from physicians. Prior to the complaint by Dr. Furnish, he had received no complaints about his pumps or pump refills.

Respondent had no memory of speaking with Dr. Furnish but believed that he "must have." Further, he acknowledged that he understood how his method of programming the pump could be confusing for a physician like Dr. Furnish looking at the telesheet and not understanding the method that he had developed and used to determine the final concentration and daily rate of infusion. In order for a subsequent physician to fill a patient pump, the subsequent physician must have his excel sheet in order to fill the pump with the intended amount of prescribed medicines; the subsequent physician could not rely on the information that respondent recorded the pump, found on the telemetry sheet. However, prior to the complaint by Dr. Furnish, regarding his pumps and pump fills, he had no problem with doctors in the community or receiving physicians.

At the time of the hearing, respondent had approximately 100 patients with implanted pumps. After the board filed the Accusation in 2018, respondent began reprogramming the pumps as patients came into the office for pump refills.

26. Because respondent was erroneously precluded from presenting expert opinion to defend himself on his care and treatment of Patient A, insufficient evidence was presented as to whether respondent failed to clearly and accurately document the concentration of initial medication that was used to fill the pump.

27. Further, respondent documented that Patient A was continuing to orally take Methadone<sup>13</sup> and Roxycodone<sup>14</sup> for pain. Notwithstanding the amount of controlled pain medications Patient A was getting through combined intrathecal and systemic drug therapies, respondent gave verbal orders for an intramuscular injection of Dilaudid 4 mg for Patient A at this visit. Dr. Pope explained that, considering the pharmacokinetics of the intramuscular route of delivery (of Dilaudid) and the significant dose of medicine that Patient A received intrathecally, there was a need for a period of observation because of concern about respiratory depression; and this was not indicated in the chart note. Dr. Pope did not identify what the period of observation should have been.

28. Respondent acknowledged that he ordered the intramuscular injection of Dilaudid because Patient A was experiencing significant pain after the pump fill; however, he disputed that there was no period of observation. Normally, there is a period of observation of 20 minutes or more to handle issues related to the pump fill, such as the telemetry, re-programming the pump, writing out prescriptions, doing a wound check and allowing a patient to get dressed. Though respondent did not

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<sup>13</sup> Pursuant to Health and Safety Code section 11055, Methadone is a Schedule II controlled substance. Pursuant to Business and Professions Code section 4022, Methadone is a dangerous drug.

<sup>14</sup> Pursuant to Health and Safety Code section 11055, Roxycodone is a Schedule II controlled substance. Pursuant to Business and Professions Code section 4022, Roxycodone is a dangerous drug.

document in Patient A's chart that there was an observation period or what that was, his statements regarding what occurred was logical.

29. Based on the facts, on October 9, 2012, after the pump fill, respondent ordered the intramuscular injection of 4 mg of Dilaudid. Respondent established that there was a period of observation after the pump fill.

30. Complainant alleged that, on October 2, 2017, following a pump pocket fill of Patient A's intrathecal pump, respondent sent her home and failed to observe Patient A after the single dose of Naloxone and evaluate potential side-effects, including, but not limited to, opioid over-dosage.

The issue is whether a pump pocket fill occurred, and if it did, whether there was a sufficient period of observation by respondent thereafter.

In support of the allegation, complainant offered the testimony of Dr. Pope. Dr. Pope explained what a pump pocket fill<sup>15</sup> is, how a clinician knows when a pump pocket fill has occurred, the dangers associated with a pump pocket fill and what steps are taken in the event a pump pocket fill occurs. Thereafter, he evaluated the October 2, 2017 chart note.

Dr. Pope explained that, when the intrathecal pump is refilled, the goal is to place the needle in the reservoir, remove the medicine left in the pump and then refill the pump with new medicine to the volume that the pump accommodates. Often, the

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<sup>15</sup> When the pump is implanted, there is a process called epithelialization that occurs; which essentially creates a connective tissue holding device for these spots. This is the pocket.

needle is placed in the reservoir and then a sequential aspiration is done; that is, the clinician injects 5 cc, pulls back 3 cc repeatedly; the clinician confirms that the needle is where he wants it to be before he deposits large volumes of medicine with high concentrations around the pump. If a pump pocket fill occurs with an opioid-based medicine, within five to 10 minutes, the patient exhibits signs of an opioid overdose; the patient becomes somnolent, confused, and potentially unresponsive. This is a life threatening event, a medical emergency.

If a pump pocket fill occurs, the standard of care requires the clinician to identify that the event occurred; put the needle in and suck out the medicine from the pocket and then administer a reversal agent - Naloxone<sup>16</sup>. Depending on the clinical scenario, frequently, the patient is dosed every 30 to 45 minutes. If the pump pocket fill occurs in an outpatient setting, the standard of care requires that, after the reversal agent is administered, the patient is taken to the hospital, by ambulance for overnight observation.

31. In Dr. Pope's opinion, according to the chart note for October 10, 2017, after respondent attempted to refill the pump, there was a clinical scenario that suggested that some of the medicine may have gone around the pocket instead of into the pump; five minutes after they completed the procedure, Patient A experienced "euphoria" and became sedated. Further, the chart note stated:

At 12:20 p.m., Patient A's vital signs were obtained; at 12:25 p.m., respondent injected an intramuscular dose of 0.4 mg Narcan (diluted over 10 cc) into her right deltoid; at 12:30

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<sup>16</sup> Naloxone is a medication designed to rapidly reverse opioid overdose.

p.m., Patient A's vital signs were reassessed; at 12:34 p.m., a (0.01 mg) dose of Narcan was administered; at 12:35 p.m., Patient A's vital signs were reassessed, and she reported that the feeling of euphoria had resolved; at 12:40 p.m., her vital signs were reassessed. Twenty-five minutes after Patient A reported feeling "euphoria," she was discharged from respondent's clinic. According to the chart note, "[Patient A's] caregiver was given remaining amount of Narcan in syringe with atomizer attachments and given instructions for use should the patient again display symptoms of opioid overdose.

In Dr. Pope's opinion, respondent's clinical decisions, made during this emergent event, showed that he responded as if Patient A had suffered an "opioid overdose" due to a pump pocket fill; despite the immediate onset of Patient A's "euphoria" within minutes of injecting significant concentrations of Fentanyl, Dilaudid, Marcan and Ketamine into her body, there is no evidence in the chart note that respondent attempted to remove the medicine that may have leaked in and around the pump. In Dr. Pope's opinion, given that the pump pocket fill occurred, the period of observation by respondent and/or his staff was inadequate.

32. Respondent adamantly denied that the pump pocket fill occurred when he filled Patient A's pump on October 10, 2017. He explained he used ultrasound, then he put the needle down and hit the bottom of the reservoir; in addition, he aspirated "one ml of residual drug sitting down here," it was clear, and had no biological material in it; so, he knew he was in the pump; then he put the medication into the pump {stopping every three to four ml and pulling back one or two ml}; he did that

four or five times during the fill; this confirmed that he was in the pump and nowhere else; after he filled the pump, he pulled the needle out quickly. Respondent stated that, as he pulled the needle out, it had medication in the tubing and in the needle; occasionally, when the needle is pulled out, a small drop of medication is expressed; that drop gets absorbed quickly and causes a brief period of sedation. In respondent's opinion, this is what occurred to Patient A; as the needle came out, a small drop of medication caused a "very transient period of sedation;" therefore, he acted properly.

33. In order to ascertain whether a pump pocket fill occurred, Dr. Pope's and respondent's testimony and the bases of their testimony were considered. As stated previously, Dr. Pope's education, training and involvement in the pain management community exceeds that of respondent but respondent has more experience. In this case, Dr. Pope relied on the medical chart to render his opinions. However, respondent was present on October 2, 2017; his explanation for the reasons that he was in the pump were reasonable and logical and consistent with the medical record. For the foregoing reasons, respondent's testimony that there was not a pump pocket fill and that he acted appropriately are more credible and reliable.

34. Insufficient evidence was offered to establish that, on October 2, 2017, a pump pocket fill occurred; therefore, it was not established that the period of observation of Patient A was inadequate or that respondent established that respondent otherwise acted inappropriately.

35. Respondent routinely issued prescriptions to Patient A for concomitant use of controlled substances including, but not limited to, MS Contin<sup>17</sup>, Roxicodone, and Phentermine<sup>18</sup>. Respondent did not prescribe the benzodiazepines<sup>19</sup>.

In 2017 respondent routinely prescribed a combination of systemic (oral) opioids, intrathecal opioids and other controlled medications (including MS Contin, Roxicodone, Soma<sup>20</sup> and Phentermine. Expert testimony established that the risks

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<sup>17</sup> MS Cantin is a brand name for morphine. Pursuant to Health and Safety Code section 11055, subdivision (b), MS Contin is a Schedule II controlled substance; pursuant to Business and Professions Code section 4022, MS Cantin is a dangerous drug. The DEA has identified Phentermine as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2017 Edition), at p. 50.)

<sup>18</sup> Pursuant to Health and Safety Code section 11057, subdivision (f), Phentermine is a controlled substance; pursuant to Business and Professions Code section 4022, it is a dangerous drug. The DEA has identified Phentermine as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2017 Edition), at p. 50.)

<sup>19</sup> Pursuant to Health and Safety Code section 11057, subdivision (d), benzodiazepines are Schedule IV controlled substances; pursuant to Business and Professions Code section 4022, it is a dangerous drug.

<sup>20</sup> Soma is a brand name for Carisoprodol; pursuant to Health and Safety Code section 11057, subdivision (d), Soma is a Schedule IV controlled substance; pursuant to Business and Professions Code section 4022, Soma is a dangerous drug. The DEA has identified Soma as a drug of abuse. (Drugs of Abuse, Resource Guide (2017 Edition), at P.50.)

involved were respiratory depression, overdose, and death. Dr. Pope defined respondent's prescribing pattern as "[p]olypharmacy, using more than one medicine to treat a patient." Prescriptions for these dangerous drug combinations were issued to Patient A on multiple dates including, but not limited to, January 23, 2017; February 21, 2017; March 6, 2017; April 28, 2017; June 1, 2017; August 7, 2017; and October 2, 2017, which demonstrated a pattern of polypharmacy.

36. Respondent did not document in the medical records justification for prescribing a complex and concurrent regimen to Patient A.

37. Complainant alleged that the medical records that respondent maintained for Patient A demonstrated that he had knowledge of her drug seeking behavior and did not address her drug seeking behavior. In support of the foregoing, complainant offered the testimony of Dr. Pope. He described the criteria that the pain management physician uses to monitor aberrant drug behavior, the standard of care applied when a physician identifies such behavior and identified the aberrant behavior in Patient A's chart and action/inaction taken by respondent.

38. One method to monitor aberrant drug behavior/drug seeking behavior is pulling the Controlled Substances Utilization Review and Evaluation System (CURES) report<sup>21</sup>.

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<sup>21</sup> A CURES report is an online database that allows for inspection of controlled substances that are prescribed to patients, the physician who is prescribing the medication and the pharmacy that is filling the prescription.

The October 29, 2013 chart note states, in part, that, based on the CURES report, Patient A was inconsistent<sup>22</sup> because there were multiple prescriptions for Promethazine and Soma; respondent called (or instructed his staff to do so) the pharmacy to inform that there were multiple prescriptions for Promethazine and Soma. Further, respondent stated that, at the next office visit, he would go over the opioid contract.

Following the October 29, 2013 office visit, there were three more office visits through 2013. According to Patient A's medical record, on October 29, 2013, and at the following office visits, Patient A continued to receive Promethazine, Soma, Roxicodone, MS Contin and intrathecal therapy with a daily dose of Fentanyl of 7.5 mg/day. There is no evidence in Patient A's medical records that respondent obtained a subsequent CURES report, urine drug sample (UDS) or discussed the (aberrant behavior/drug seeking behavior) issue or discussed the opioid contract with Patient A.

39. Besides evaluating CURES reports, in order to evaluate potential aberrant drug behavior, clinicians may obtain a UDS to monitor what medicines the patient is taking and/or is not taking; the clinician looks at what the patient is being prescribed

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<sup>22</sup> Dr. Pope explained that the clinician considers what the patient is being prescribed, confirms that with a CURES report and then looks to see what is in the patient through a urinary drug screen (UDS); those things have to line up in order for the patient to be consistent with prescribing or with taking the medicines. For example, if the patient is prescribed Hydrocodone, then the UDS report should be positive for Hydrocodone; however, if it is negative for Hydrocodone, it is inconsistent.

and looks for its presence in the urine sample and the absence of medicines that are not prescribed to the patient.

40. Patient A's chart note for April 27, 2016 states, in part: LCMS<sup>23</sup> from April 1, 2016, consistent/inconsistent; Patient A was taking MS Contin orally, and she had Dilaudid in her intrathecal pump; she reported taking her medicines as directed and did not know why the MS Contin was not detected; respondent notified the laboratory to re-run and re-test LCMS as Dilaudid runs through the intrathecal pump and review at next office visit.

Dr. Pope explained that there are clinical scenarios where a prescription is given to a patient that is not detected in a urine compliance test. Respondent prescribed Morphine orally and should have been detected in the urine sample; Dilaudid "is running intrathecally through the pump; because the doses are relatively low systemically," sometimes they are not detected. However, the Dilaudid may be detected in the sample under certain circumstances; it depends on the sensitivity of the test, if the testing is at a really low threshold or if a high complexity test is performing the test.

41. Dr. Pope also explained that, when there is an inconsistent UDS, the standard of care is to repeat the UDS.

Between April 27, 2016, and December 22, 2016, with the exception of June 2016, Patient A had office visits on a monthly basis. From the inconsistent test in April

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<sup>23</sup> LCMS is a urine drug screen that "dequantifies the sensitivity or specificity of the tests. There are different types of urine drug screenings;" "that would highlight the type of urine drug screen."

2016 until December 2016, there was nothing in Patient A's medical records that she was testing consistently; there is no indication that a UDS was performed following the consistent/inconsistent test in April 2016.

Patient A's chart note for May 25, 2017, stated "LCMS from May 19, 2017, was inconsistent, negative for MS Contin." Since respondent was being prescribed MS Contin, the expectation is that it would be present in her urine sample. Dr. Pope explained the reasons that, though the patient is prescribed MS Contin, it did not appear in the urine sample. If the patient is prescribed a medicine, and it does not appear in the urine sample, there are a couple of things that could be responsible. One of them is the test; the test may be flawed because the detection limit for the medicine is not low enough to detect the medicine. It could be a patient metabolism issue; some patients metabolize medicines faster than others; so, that would be an issue. The other is that the testing is accurate and metabolism is relatively normal, so the medicine is not actively in the patient. That could mean that the patient did not take the medicine for a few days, or it could mean the patient never took the medicine. That could indicate diversion and misuse. The other scenario is that the patient is taking the medicine but the patient overtook it earlier in the month; the patient comes in for the 30-day refill, and the patient has been out of the medicine for a handful of days; but, that is not taking the medicine as prescribed. That is of concern as well.

42. There is insufficient documented evidence in the record to establish that respondent documented discussion with Patient A about her aberrant drug behavior (in 2016 and 2017) about the reasons and/or explanations for the inconsistencies.

43. It was established that, between 2011 and 2017, notwithstanding his knowledge of Patient A's documented history of "drug seeking" behavior respondent continued to prescribe "massive" amounts of controlled pain medicines. The chart

notes for Patient A do not adequately document any discussion with Patient A about the reasons and or explanations for the inconsistencies.

#### **PATIENT A - GROSS NEGLIGENCE**

Because respondent was erroneously precluded from presenting expert opinion to defend himself on his care and treatment of Patient A, there is insufficient evidence to any extreme departure from the standard of care. Complainant failed to demonstrate respondent committed gross negligence with respect to Patient A.

#### **PATIENT A- REPEATED NEGLIGENT ACTS**

44. Because respondent was erroneously precluded from presenting expert opinion to defend himself on his care and treatment of Patient A, there is insufficient evidence to establish respondent engaged in repeated negligent acts in his care and treatment of Patient A.

#### **PATIENT A-INCOMPETENCE**

45. Because respondent was erroneously precluded from presenting expert opinion to defend himself on his care and treatment of Patient A, there is insufficient evidence to establish that respondent's care and treatment of Patient A demonstrated incompetence.

#### **PATIENT A- REPEATED ACTS OF CLEARLY EXCESSIVELY PRESCRIBING**

46. Because respondent was erroneously precluded from presenting expert opinion to defend himself on his care and treatment of Patient A, there is insufficient evidence to establish that respondent committed repeated acts of clearly excessive prescribing drugs or treatment to Patient A.

## **PATIENT A- FAILURE TO MAINTAIN ADEQUATE AND ACCURATE RECORDS**

47. Because respondent was erroneously precluded from presenting expert opinion to defend himself on his care and treatment of Patient, there is insufficient evidence to establish that respondent failed to maintain adequate and accurate records in connection with his care and treatment of Patient A.

### **Patient B<sup>24</sup>**

48. Dr. Pope identified the records that he reviewed and upon which he relied in rendering his opinions regarding respondent's care and treatment of Patient B, including the following:

- Complaint to CCU,
- Death Certificate for Patient B,
- Certified copy of the examiner's report,
- Certified copy of death investigation report,
- Signed Release of Medical Information for San Diego Comprehensive Pain,
- Signed Release of Medical Information for Veterans Affairs Hospital,
- Certified copy of Patient B's medical records for San Diego Comprehensive Pain,
- Respondent's curriculum vitae, CMEs, and opioid maintenance contract,
- Respondents retention of medical records policy, and
- Transcript of respondent's interview.

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<sup>24</sup> The letter is used to maintain patient confidentiality.

49. Between 2004 and November 2013 respondent provided care for Patient B. The period relevant to this proceeding was May 2011 until November 2013.<sup>25</sup>

Among other things, Patient B had diagnoses of lumbar radiculopathy, spinal stenosis, lumbar spondylosis and failed back surgery syndrome. He had a history of post-traumatic stress disorder (PTSD), obstructive sleep apnea, hyperlipidemia, hypertension, and obesity; in May 2011, respondent added the diagnosis of opioid dependence; in 2013, respondent added diagnoses of anxiety and depression.

On April 19, 2015, Patient B died of a drug overdose. The medical examiner's autopsy report determined his cause of death was from "mixed medication intoxication (Fentanyl, Oxycodone, Oxymorphone, and Diazepam)."

50. A review of Patient B's medical record, between January 2011 and November 2013, provided insight into respondent's care and treatment of this patient.

Between January 2011 through May 2011, respondent prescribed Vicodin 5/325 mg, two to four times a day, and Valium 10 mg, one pill by mouth before noon.

On March 10, 2011, under diagnosis, respondent first identified Opioid Dependence.

On the April 5, 2011 chart note, under Medications, among other things, he included Vicodin and Valium; under Treatment Provided, respondent stated that he reviewed the urine screen that was collected on March 10, 2011; it

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<sup>25</sup> Conduct occurring more than seven years from the filing of the initial Accusation (April 27, 2018) involving Patient B is for informational purposes only and not alleged as a basis for disciplinary action.

was positive for Percocet and Benzoyllecgonine<sup>26</sup>, also he stated that he would not prescribe controlled substances until Patient B had a clean UDS; during this office visit, Patient B provided a UDS. It is unclear whether respondent issued the prescription.

On the May 3, 2011 chart note, under Medications, among other things, respondent identified Vicodin, Valium and Toradol; under Treatment Provided, respondent stated the UDS will be discussed at the next office visit (not available); further, respondent stated: "Cont all other meds as prev ... " From the chart note, it is unclear whether respondent issued a prescription for the Vicodin and Valium; based on the foregoing language, presumably he issued the prescriptions.

On the June 23, 2011 chart note, under Subjective Complaints, among other things, respondent stated, at the time, Patient B reported that he was not taking pain medications or muscle relaxants; under Medicines, among other things, respondent stated Vicodin and Valium; under Treatment Provided, among other things, respondent

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<sup>26</sup> Benzoyllecgonine is a metabolite for cocaine. Dr. Pope explained that cocaine does not last very long in the body; if Patient B had been tested the day before, he would have been positive for cocaine.

reported: "D/C Vicodin and Valium - due to inconsistent UDS; Pt provided own medication supply."

Regarding the UDS collected on April 5, 2011, the LCMS qualitative report was issued on May 2, 2011, and the quantitative report was issued on May 5, 2011; it was positive for Benzoylecgonine, a metabolite of cocaine, an illicit drug. There was no mention in this May 3, 2011, chart note or the June 23, 2011, chart note.

On the September 8, 2011 chart note, under Subjective Findings, Patient B reported: "At this point in time he continues to use Vicodin on a very PRN basis states that it is from an old rx that he has and states that it is very effective in terms of pain control. Therefore, would like to discuss w/MD about possibly restarting the medication. Pt. is req ... req refills on: Valium, Vicodin, Abilify and Zoloft." Under Treatment Provided, respondent stated that he "obtained a routine UDS" "using LCMS and quantitative confirmation of positives/negatives;" and he "restarted Norco<sup>27</sup> 5/325 1 PO QID #56, 2 week supply and Valium 10 mg QAM #14;" and ordered "testosterone 300 mg given im."

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<sup>27</sup> Norco, an opioid, is a hydromorphone preparation.

On the October 6, 2011 chart note, under Subjective Findings, Patient B reported that he continued to use Vicodin on an as needed basis for pain control, and it was very effective in terms of pain control when needed. Under Medications, respondent identified medicines that he had previously prescribed for Patient B. Under Treatment Provided, he stated, among other things, "testosterone 400 mg given im;" "Continue other meds as prev;" "Toradol 60 mg given im;" "Pt provided own med supply;" "Refilled Norco 5/325 1 PO QID #120 and Valium 10 mg 1 PO QAM;" "Refilled testosterone 200 mg/ml multidose vial."

Patient B had no office visits between October 6, 2011, and May1,2012.

On the May 1, 2012 chart note, Patient B reported that he was not taking medications because he wanted to know how bad the pain was; Patient B wanted to discuss "rf int of his medication." Under Medications, respondent listed, among other things, Norco, Toradol, and Testosterone. Under Treatment Provided: "Cont other meds as prev;" "Using LCMS and quantitative confirmation of positives and negatives; a random UDS obtained today;"

On the May 15, 2012 chart note, under Subjective Findings, respondent documented that Patient B reported thathe continued to use Norco which he stated was effective but would like to discuss possible medication increase to

further decrease levels of pain. Under Medicines, respondent identified, among other things, "Norco 5/325 1 PO QID-PRN/Valium 10 mg QAM." Under Treatment Provided, respondent stated: Increase "Norco 5/325 2 PO QID #112 (2 week supply);" Also, "MD to review UDS from 5/1/12 - Pt consistent."

On the June 26, 2012 chart note, under Subjective Findings, respondent reported that Patient B continued to use Norco which was effective in decreasing levels of pain and increasing function and quality. Under Medications, he identified Norco and Valium, consistent with the prescription issued on May 15, 2012; there is no indication in the chart note that respondent refilled these prescriptions.

On July 25, 2012, respondent continued and refilled Norco and Valium. Under Subjective Findings, respondent repeated the statement "that Patient B continued to use Norco which was effective in decreasing levels of pain and increasing function and quality." Under Medications, he identified Norco, Toradol and Testosterone. Under Treatment Provided, respondent reported: "Continue other meds as prev."

On the August 24, 2012 chart note, under Subjective Findings, again respondent repeated "Patient B continued to use Norco which was effective in decreasing levels of

pain and increasing function and quality." Under Medications, he identified "Norco 5/325 1 PO QID-PRN/Valium 10 mg QAM, Toradol and Testosterone." However, respondent reported "Faxed rx refill for Norco 5/325, 2 PO QID #240; Valium 10 mg, 1 PO QAM #30."

On September 24, 2012 chart note, under Subjective Findings, again respondent stated: "That W/C denied refill of Norco from last ov and hasn't had any since Friday 9/21/12;" and then repeated "Patient B continued to use Norco which was effective in decreasing levels of pain and increasing function and quality. However, was denied last rx." Under Medications, respondent identified Norco 5/325 1 PO QID-PRN/Valium 10 mg QAM and testosterone. Under Treatment Requested, respondent stated: "Please cont to authorize Norco 5/325 1 PO QID every month."

It is noted that the medications are consistent in this chart note but inconsistent with the prior month.

Patient B had no office visit in October. However, according to the CURES report, Patient B picked up Hydrocodone 5/325 mg from a pharmacy; the prescription was written by respondent.

On the November 29, 2012 chart note, under Medications, it stated Norco, 5/325, "2 PO QID-PRN/Valium 10 mg QAM;" under Treatment Provided, respondent stated:

"Norco 5/325 2 PO QID;" under Treatment Requested, respondent stated: "Please continue to authorize "Norco 5/325 1 PO QID every month."

There was an inconsistency between the medications identified under Medications in the chart note and the medications that he identified under Treatment Requested.

On January 15, 2013, Patient B reported medications working well. Respondent continued the Norco #240 and obtained a UDS using LCMS; the test results (issued on the same date) were inconsistent for Hydrocodone; the note on the report stated: "repeat 4/16/13."

On February 14, 2013, Patient B reported that the medication was working well; respondent issued prescription for Norco #240. Respondent did not discuss the inconsistent UDS report from the January office visit.

On the March 14, 2013 chart note, under Subjective Findings, respondent documented that Patient B self-increased Norco to 1.1 per day due to increased pain; Patient B reported that he did not notify respondent's practice that he had increased the medication. Patient B reported that he was out of medication. Under Treatment Provided, respondent reviewed the opioid maintenance contract with Patient B, reminding him that he could not increase medication without respondent's consent; Patient

B verbalized he understood; no further questions or concerns were addressed; respondent recorded "Inc Schedule II Norco 5/325 2 PO Q4-6Hrs NTE, 9/day #270."

Respondent did not obtain a UDS.

On April 16, 2013 chart note, under Subjective Findings, respondent stated that Patient B self-increased Norco to 12 per day approximately; he stated that he went the weekend without medication and borrowed Percocet from a friend which was still ineffective in decreasing the pain level. Respondent reviewed the opioid maintenance contract with Patient B, reminded him that he could not increase medicine without contacting respondent and waiting for direction from respondent and advised of the side effects of him increasing his own medication; respondent increased the Norco to 10/day #300.

On May 16, 2013 chart note, under Subjective Findings, respondent reported "cont to use Norco, Duexis and Valium, which Pt reports is somewhat effective in dee his pain. However, would like to discuss with MD about having a medication change. Pt states that with his inc activity level his pain inc and he has been needing to inc his meds." Under Treatment Provided, respondent stated "d/c Norco - not effective; init and p/u Roxicodone 5 mg 1 - 2 PO QID NTE 10/day #300 to start 05/16/13; refilled Valium 10 mg 1 PO QD #30;" "Collect LCMS at next ov."

On June 14, 2013 chart note, under Subjective Findings, respondent reported "pt was init on Roxicodone at last ov which pt reports was effective in dee his pain better than Norco; refilled Valium 10 mg 1 PO QD #30;" "Collect LCMS at next ov; pt cont to use Duexis and Valium which pt reports is effective in dee his pain." Under Treatment Provided, respondent stated "d/c Norco - not effective; p/u Sched II Roxicodone 5 mg 1 - 2 PO QID NTE 10/day #300 to start 6/15/13; refilled Valium 10 mg 1 PO QD #30; per MD collect LCMS at next ov (requested today)." Under Treatment Requested, respondent stated "MD req a routine urine screen using LCMS and using quantitative confirmation of pos/neg to be obtained at next ov."

In the Workers' Compensation (WC) Progress Report, dated July 15, 2013, under Present Complaint, respondent stated "Pt reports that the Roxicodone in conj with the Valium, which pt reports is effective in dee his pain." Respondent added "Anxiety State Unspecified, Depressive Disorder Not Elsewhere Classified" to Patient B's diagnoses and requested psychotherapy for treatment with Dr. Cathy Hammond twice a week for eight weeks for industrial related depression; requested refills for Roxicodone 5 mg 1 PO Q4HRS NTE 10/D #300 and Valium 10 mg 1 PO QAM #30. There was no reference to obtaining an UDS.

In the WC Progress Report, dated August 1, 2013, under Medication, respondent stated "Roxicodone 30 mg tablet 1 - 2 tablet every 4 hours PRN for 14 days, prescribe 140 tablets, and Valium 10 mg tablet 1 tablet every for 14 days, prescribe 14 tablet."

It is noted that there was a significant increase in the Roxicodone from July 15, 2013. Under Work Status, respondent reiterated the need for a referral to Dr. Hammond.

In the WC Progress Report, dated August 14, 2013, Under History of Present Illness, respondent reported, among other things, that Patient B reported for medication refill with an "agitated effect, states that dates of the Ability were messed up by the pharmacy and did not have his daily dose for the first few weeks on the month. States that the pain in his back had been so unbearable that he had to increase the dose of his-[sic] and Roxicodone and even doubling the dose of Valium was insufficient to allow him a restful night's sleep;" Patient B stated that he was "totally out of medication." "States that he went to the V.A. Hospital on the 9th and 11th for bouts of Tonsillitis and treated there with intravenous Dilaudid; still taking antibiotics though he cannot recall what the name of the antibiotic. Pt became fractious when asked to provide a routine urine sample." Under Medication, respondent stated, among other things,

"Roxicodone 30 mg tablet 1 - 2 tablets every 4 hours PRN for 14 days, dispense 140 tablets, and Valium 10 mg tablet 1 tablet once a day for 14 days, dispense 14 tablets." Under Diagnosis, respondent stated, among other things, "Opioid Type Dependence Unspecified Pattern of Use." Under Treatment Plan, respondent stated "Pt given 14 day *[sic]* supply only of pain medication *[sic]* allowing for closer observation from MD;" "MD reoriented Pat to terms of opioid contract, pt verbalized understanding regarding ER visits and committed to continued adherence to contract. MD requesting pt use Dr. Thompsons outpatient pain management program to equip pt with non-drug pain coping tools. In compliance with DOJ/DEA, a routine urine screen using LCMS and using quantitative confirmation of pos/neg obtained today to help prevent diversion and abuse."

Under Medications, Treatment Plan and Treatment Requested sections of the document, respondent referred to the amount and dosage of the Valium and Roxicodone; in addition, he issued written prescriptions for these medications. The Valium was consistent with the prescription and in the sections of this document. However, the Roxicodone was inconsistent. Under Medication, respondent stated "Roxicodone 30 mg tablet 1 - 2 tablets every 4 hours PRN for 14 days, dispense 140 tablets; the prescription issued for Roxicodone on this date was

consistent with the foregoing dosage and amount; under Treatment Plan, respondent stated "P/U Schedule II Roxicodone 5 mg 1-2 QID NTE 10/day #140 to start today." Under Treatment Requested, respondent stated, "please authorize refills" for "Roxicodone 5 mg 1 PO Q4hrs NTE 10/D #300."

The LCMS test report {collected on August 14, 2013) was issued on August 15, 2012 and was inconsistent for Hydromorphone, Oxycodone [expected to be on Hydromorphone and Oxycodone], and NorFentanyl (a metabolite of Fentanyl) [not expected to be in Fentanyl], and positive for cocaine and Benzoyllecgonine (the metabolite of cocaine), an illicit drug.

In the WC Progress Report, dated August 29, 2013, under Treatment Plan, respondent stated "P/U and int scheduled II Butrans Patch 20 mcg/hour apply 1 patch top change week #4;" and "MD reviewed LCMS patient inconsistent positive for Cocaine and fentanyl negative for Dilaudid and oxycodone." Under Treatment Requested, respondent requested psychotherapy twice a week for eight weeks for the industrial related depression; also, he requested that Patient B be authorized to "use Dr. Blake Thompsons [sic] pain management program to equip pt with non drug pain coping tools."

Under Medication, respondent noted, among other things, "Butrans 20 mcg/hour transderm patch 1 transdermal patch every week for 30 days, dispense 4 unspecified;" and, "Roxicodone 30 mg tablet 1 - 2 tablet every 4 hours PRN for 14 days, dispense 140 tablet." Under Treatment Requested, respondent requested authorization for refills for, among other things, "Roxicodone 5 mg 1 PO Q4HRS NTE 10/Day #300"; however, respondent requested "Lidoderm patches apply 1 patch to painful area 12 hours on 12 hours off." Though there is no mention of it in the WC Progress Report, apparently respondent collected a UDS during this office visit. The LCMS report was issued on September 6, 2013.

Patient B1s WC Insurance Company authorized him to be evaluated by Multidisciplinary Pain Rehabilitation Program (MDPRP); on September 9, 2013, Patient B was evaluated by a multidisciplinary team "for purposes of conducting an MTUS<sup>28</sup> guideline-compliant multidisciplinary chronic pain evaluation." Thereafter, on the same date, a report was issued. During the evaluation, among other things, Patient B reported his illicit drug use. In order to participate in the program, Patient B was required to be and remain sober'. The MDRP "requested 20 full sessions of the intensive

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<sup>28</sup> MTUS is an acronym for Medical Treatment Utilization Schedule.

multidisciplinary pain rehabilitation program. These sessions will consist of physical treatment, medical care and supervision, psychological and behavioral care, psychosocial care, vocational rehabilitation training and education."

Among other things, the report stated "One of the primary goals of the MDPRP is to teach patients to take responsibility for managing their own rehabilitation and recovery. To this end, MDPRP teaches the patient chronic pain self-management skills that include cognitive and behavioral strategies and other behavioral medicine interventions designed to decrease pain rumination and catastrophizing." MDPRP provided respondent with a copy of the report

On September 12, 2013, a UDS was collected, and the quantitative laboratory report was issued on September 17, 2013. The report was inconsistent; he was positive for Hydrocodone<sup>29</sup>. Respondent received a copy of the report from the laboratory.

In the chart note for October 1, 2013, under Present Complaint, respondent stated "Pt would like to go over UDS

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<sup>29</sup> Hydrocodone and Nor-Hydrocodone, which was not supposed to be in the patient's body, was discovered in the patient's body. Norco is a combination of Hydrocodone plus Tylenol. So this is the opioid component of the Norco that the patient was prescribed. Nor-Hydrocodone is a metabolite of Hydrocodone.

results to discuss with MD starting pain medication Roxicodone again to help dee pain. Pt states at last ov was initiated on Butrans patch which pt found to be eff in dee pain level but had trouble with patches coming off when he inc activity and started sweating." Under Medication, among other things, respondent stated "Roxicodone 30 mg tablet 1-2 tablet every 4 hours PRN for 14 days, dispense 140 tablet." Under Treatment Plan, respondent stated "Pt to continue with medication as prev; MD discussed with pt the importance of being compliante [sic] with UDS and contract signed with office at initial ov; MD also informed pt the importance of taking medication as prescribe." "Per MD will not be able to rx prev medication until pt is compliant;" "per MD will continue to rx Butrans patch to help keep pt in compliant until UDS is consistent and as well as DEA CURES."

In the chart note for November 12, 2013, under Present Complaint, respondent stated "Patient reports to clinic stating that he is unable to get and [sic] appointment with his new Dr and would like Dr. Smith to carry his refills for another month, stating that his adjuster advised him to return to the clinic. States that the Butrans Patch is not effective, it will adhere to his skin only sometimes;" "Patient expresses desire to return to opioid therapy and would like to discuss prescription options with MD." "Patient states that he has been without medications for the past two

weeks and as a result can only leave the house with great difficulty and has been out of his home only once due to anxiety attacks causing him to be fearful of leaving." Under Medications, respondent listed, among other things, "Roxicodone 30 mg tablet 1-2 tablet every [the number is illegible] hours PRN for 14 days, dispense 140 tabs." Under Treatment Plan, respondent stated, among other things, "Patient advised that due to inconsistent urine and planned start to another MDs practice rio Schedule 11 substances will be prescribed, should he require medication he is to go to VA Hospital for 13 day [sic] supply to carry him until appointment on 11/25/2013 with Dr. Thompson."

51. Between May 2011 and November 2013, respondent prescribed escalating doses of opioids in combination with other controlled substances, including benzodiazepines, antidepressants, muscle relaxants and testosterone.

52. In May 2011, respondent prescribed Vicodin 5/325 two to four times a day. In September 2011 he prescribed Vicodin four times a day. According to the chart note, on October 6, 2011, respondent discontinued Vicodin because of the inconsistent UDS; without explanation in the chart note, there were no office visits by Patient B between October 2011 and May 2012. On May 1, 2012, respondent prescribed Norco 5/325, one pill, four times a day. On May 15, 2012, the next office visit, respondent increased the Norco from one to two pills, four times a day which continued until February 2013. It is noted that, according to the medical record, there was no office visit in October 2012, and on this date Patient B obtained a prescription of Norco #240. Respondent continued prescribing the same dose and amount of

Norco on a monthly basis until May 2013, when he discontinued the Norco and commenced Roxicodone 5 mg one to two tablets a day; in August 2013, respondent increased the Roxicodone 30 mg one to two times a day.

53. Dr. Pope explained that, as early as 2009, there was guidance describing that, if a patient received more than 200 MME the likelihood of overdose and death is higher statistically; the standard of care was to avoid prescribing above 200 MME per day. In 2013, the CDC recommendation was to prescribe no more than 90 MME.

Over the course of treatment, respondent's opioid prescribing increased; Dr. Pope explained that tolerance occurs with repeated exposure to these medications which can lead to the need to increase the dose to obtain the same analgesic effect; he said "this is predictable." During the relevant period, the opioid doses on the CURES report (August 14, 2012, through August 14, 2013) reflected the following:

- March 14, 2013 - Norco 5-325 #270 (9/day) 45 MME
- May 16, 2013- Oxycodone 5 mg (10/day) #300 75 MME
- June 14, 2013 - Oxycodone 5 mg (10/day) #300 75 MME
- July 15, 2013 - Oxycodone 5 mg (10/day) #300 75 MME
- August 14, 2013 - Roxicodone 30 mg every four to six hours as needed for pain (10/day) #140 450 MME

54. Between May 2011 and November 2013, respondent had knowledge of Patient B's documented history of opioid dependence, drug abuse, depression and other aberrant drug behaviors. During the course of treatment, respondent had repeated inconsistent drug test results. On more than one occasion, he had a urine

sample test positive for the metabolite of cocaine and/or cocaine. There were inconsistencies in Patient B's UDSs and CURES report, including but not limited to, Patient B's UDS was inconsistent for Vicodin and Valium on June 23, 2011; Patient B admitted that he misused his prescription on March 14, 2013 and April 16, 2013; and Patient B's urine sample, collected on August 14, 2013, was positive again for cocaine. Patient B admitted on several occasions that he self-increased the amount of opioids he was taking; and finally, on one occasion, he admitted that he took Percocet without prescription.

Despite the facts in the foregoing paragraph, respondent continued to prescribe large amounts of controlled substances, including opioids, to Patient B.

55. Respondent, in the chart notes for Patient B during this time frame, did not adequately document discussion with Patient B about the reasons and/or explanations for the inconsistencies.

56. Despite multiple red flags "involving drug abuse and depression, respondent did not document any discussion with Patient B regarding a referral to addictionology or rehabilitation facility. However, respondent sought authorization from Patient B's WC insurance company for him to obtain therapy for his depression. No evidence was offered to establish whether Patient B was authorized to obtain psychotherapy for his depression or whether Patient B, in fact, obtained the psychotherapy.

In August 2013 respondent sought authorization for Patient B to attend MDPRP. Respondent explained that, in his opinion, this program is more effective than a recovery or addiction program. On September 9, 2013, a multidisciplinary team performed an evaluation of Patient B and thereafter issued a report with the same

date. According to the report, the program would teach Patient B responsibility for managing his chronic pain and focus on decreasing symptoms of depression and anxiety. In order to participate in the program, Patient B was required to remain sober, and MDPRP had the expectation that respondent would work with Patient B to stabilize Patient B's pain medications. According to the report, it was recommended that Patient B be authorized to attend 20 sessions. Presumably, the WC insurance company authorized Patient B to attend and he agreed to do so because the November 2013 chart note discusses Patient B's scheduled appointment with Dr. Thompson later in November 2013.

Based on the foregoing, respondent referred Patient B to an appropriate program for his drug abuse and drug seeking behavior.

57. In a chart note, dated November 29, 2012, respondent documented that Patient B requested a different dosage of medication in order to help with his depression. On January 15, 2013, the next charted visit, there was no documentation of a follow up on Patient B's request for a different dosage. However, it was documented that Patient B had been experiencing increased anxiety but with no further comment or follow up charted in the note.

58. There are multiple inaccurate chart notes documenting conflicting information regarding what medication was being prescribed and taken.

## **PATIENT B- GROSS NEGLIGENCE**

59. Expert testimony established that, respondent prescribed excessive amounts of opioids, including, but not limited to, on October 1, 2013, when he issued a prescription for Roxicodone (30 mg) (#140) amounting to ten tablets daily.

60. In respondent's opinion, regarding his care and treatment of Patient B, he acted within the standard of care and explained.

Respondent was familiar with the board's guidelines as well as the CDC guidelines regarding opioid prescribing. In respondent's opinion, the board guidelines placed "no ceiling on the prescribing dose of opioid agonist; the board recognizes that, in certain clinical cases, large doses may be needed in the treatment of chronic pain patients; however, the board recommended using caution." Regarding the foregoing, respondent did not clarify the time frame to which he was referring. Regarding the CDC guidelines, respondent stated that, in 2016, "in response to the opioid epidemic," the CDC "put forth guidelines for primary care physicians," which recommended "80 or 90 MME;" but, "it was meant to be a guideline for primary care physicians and opioid naive patients, not a guideline for specialists in pain medicine or for patients who were already opioid tolerant."

Respondent explained that, in recent years, there has been criticism in the literature about relying on MME "daily dosage;" "this is causing significant restriction on access to analgesics, particularly patients" in his practice; "it has a chilling effect on our ability to prescribe; the problem is patients who present to a practice who are on a dosage of 90 MME or greater. Do we have to wean them down? How do we document the justification for continuation?" So the issues revolved around these "arbitrary guidelines" put forth by the CDC, and the CDC recognized that these were only supposed to be guidelines for primary care physicians or opioid naive patients. "But, because of the environment today, with the amount of opioid overdoses, they have become adopted more as not guidelines but mandates, and that is leading to a fair amount of disruption in patient care and in the prescribing of opioids." It's important to remember that, from 1990 through 2010, when "we [meaning my specialty] would

go to our symposiums, they beat into our heads that there was no ceiling on opioids." That was the philosophy. Around 2015/2016, "things changed because of the significant amount of opioid deaths, accidental opioid deaths, and then the Fentanyl coming in from Mexico that was manufactured in China. There's been a paradigm shift in the community, which put a very big chill on prescribers so that we were afraid to prescribe in many cases more than the 90 MME doses. In so doing, we have to really document why we're doing it, which I understand. But a lot of patients are suffering." So, instead of a guideline, "as we're seeing with me here today, this is being somewhat utilized to criticize my prescribing techniques and my past prescribing practices."

Finally, respondent stated that the CDC has since written articles "walking back their initial guidelines as they recognized that it was causing harm to patients and limiting access to appropriate patients such that they were unable to get their opioid analgesic pain medication. They walked it back and provided further clarification," Respondent did not explain or offer evidence to establish what he meant by the foregoing testimony.

61. Respondent's arguments, set forth in the foregoing paragraph {Finding 72) are not persuasive. From respondent's testimony, it is clear that he understood the standard of care and believed that he was not required to comply because he was a pain management specialist exercising his judgment regarding Patient B. More specifically, he understood the potential for overdose and death by prescribing MME doses that were more than twice the recommended MME dose (of 200 MME). Finally, as stated previously, based on Dr. Pope's education, training and experience, Dr. Pope's testimony is more persuasive.

62. Expert testimony established that respondent did not properly monitor and manage Patient B's drug use.

Dr. Pope explained that when a patient tests positive for an illicit drug, "it's very common for people to be discontinued on opioid-based therapy and either discharged from the practice with referral to an addictionologist or, typically, a continuation in the practice, Just without the use of controlled substances to maintain their discomfort." Dr. Pope stated, this is true, "even after only one dirty test," because "illicit substances, like methamphetamine and cocaine, typically carry a greater weight because of the drug abuse behavior that typically correlates with it." Further, Dr. Pope explained that, if there is a pattern of inconsistency in drug tests, that is "provider dependent." "Clearly a change that needs to occur." The purpose of sampling is to determine compliance. "If there's no compliance in the sample," "the patient's not a candidate to continue opioid based therapy."

Based on noncompliance and inconsistent urine tests, including testing positive for morphine when respondent had not prescribed this. As such, he should have discharged Patient B from his practice or, at minimum, modified or reduced his prescription of Schedule II controlled substances. He did not.

In Dr. Pope's opinion, respondent's management of Patient B's pain medications was "lax". He did not do enough to make sure this patient was with or without Schedule II medicines with the presence of an illicit substance.

Expert testimony established that respondent's care and treatment of Patient B constituted an extreme departure from the standard of care, specifically:

- For continuing to prescribe despite urine confirmation results that indicated positive for cocaine; and

- For continuing to prescribe controlled substances while respondent was using illicit drugs (cocaine) and his UDS test screen results were inconsistent both for expected medications he prescribed and unexpected prescription medications he did not prescribe;

63. Based on the medical records, there were chart notes documenting conflicting information regarding what medications were being prescribed and Patient B was taking. This constitutes an extreme departure from the standard of care.

#### **PATIENT B - REPEATED NEGLIGENT ACTS**

64. In his care and treatment of Patient B, respondent engaged in repeated negligent acts.

#### **PATIENT B - REPEATED ACTS OF CLEARLY EXCESSIVELY PRESCRIBING**

65. Expert testimony established that respondent committed repeated acts of clearly excessive prescribing drugs or treatment to Patient B.

#### **PATIENT B - FAILURE TO MAINTAIN ADEQUATE AND ACCURATE RECORDS**

66. Expert testimony established that respondent failed to maintain adequate and accurate records in connection with his care and treatment of Patient B.

## **Patient C<sup>30</sup>**

67. Dr. Pope identified the records that he reviewed and upon which he relied in rendering his opinions regarding respondent's care and treatment of Patient C, including the following:

- Complaint from CCU,
- Certified copy of Patient C's medical examiner's investigative report, autopsy report and toxicology report,
- Certified copy of Patient C's death certificate,
- Certified copy of death investigation report from San Diego County Sheriff's Department,
- Signed information releases for records maintained at Sharp Hospital, Alvarado Hospital, respondent's office and the Spine Institute of San Diego,
- Certification of no records from Sharp Hospital,
- Certified copy of medical records from Al Varado Hospital,
- Certified copy of medical records from respondent's office,

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<sup>30</sup> The letter is used to maintain patient confidentiality.

- Certified copy of Patient C's medical records from the Spine Institute of San Diego,
- Respondent's Curriculum Vitae and CME, and
- Transcript of respondent's interview.

68. Between May 1, 2008, and July 5, 2012, respondent treated Patient C for chronic pain from a work related injury.<sup>31</sup> The period relevant to this proceeding is May 12, 2011, through July 5, 2012.<sup>32</sup> Patient C was diagnosed with "L4 to S1 spondylosis, L4 through S1 facet sclerosis, bilateral lumbar radiculitis, L4-L5 spinal stenosis, facet hypertrophy at L4 through S1 and disk annular fissure L4-L5."

On July 22, 2012, Patient C died of a drug overdose while he was under respondent's care. The medical examiner's autopsy report determined her cause of death was from "acute Oxycodone, Carisoprodol, and Diazepam intoxication."

69. In his report and during the hearing, Dr. Pope reviewed Patient C's medical records, stated each medicine and identified the classification of the medicine. In Dr. Pope's opinion, respondent excessively prescribed controlled substances to Patient C; he managed Patient C on many medication classes including, but not limited

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<sup>31</sup> Conduct occurring more than seven years from the filing date of the initially filed Accusation (April 27, 2018) involving Patient C is for informational purposes only and is not as a basis for disciplinary action.

<sup>32</sup> Conduct occurring more than seven years from the filing date of the initially filed Accusation (April 27, 2018) involving Patient C is for informational purposes only and is not alleged as a basis for disciplinary action.

to, opioids (long-acting and short-acting)<sup>33</sup>, multiple benzodiazepines, neuropathic pain medication, multiple muscle relaxants at the same time, and an antiemetic. Dr. Pope characterized this as "overabundance of layering" of medications and explained that this occurs when "a pharmacologic agent with the same mechanism or reaction or a similar mechanism of action, with potentially similar benefits and side effects, are given to the patient simultaneously." When Dr. Pope reviewed Patient C's medical records, he highlighted multiple chart notes from 2011 and 2012, where, in Dr. Pope's opinion, respondent prescribed an excessive number of controlled substances that performed the same or similar mechanisms of action.

70. In respondent's opinion, he acted within the standard of care when he provided care and treatment for Patient C, that he appropriately prescribed for this patient, that he did not excessively prescribe because she "was alert and oriented," and he was able to provide pain relief for her such that she had a better quality of life.

Respondent described the treatment Patient C had received since her injury in 2006. In his opinion, the doses he prescribed were not excessive because they were

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<sup>33</sup> Dr. Pope described the difference between long-acting opioids and short-acting opioids; exclusive of Morphine, all opioid-based therapies are short-acting. It is the packaging around the medicine that crease a long-acting slow release.

Long-acting analgesics are typically employed when the dosing frequency of short-acting agents is frequent and the pain experience is more continuous than intermittent or with incident pain. To avoid peaks and valleys of dosing with short-acting analgesics throughout the day, a long-acting medication is employed to deliver a more continuous dose.

within the Food and Drug Administration guidelines, and he had not received complaints about his prescribing practices from other physicians who were treating the patient. Respondent did not dispute that he prescribed two benzodiazepines for Patient C and explained the purpose that he prescribed the medicines.

71. Regarding respondent's medical records for Patient C, Dr. Pope stated, in part:

Medical documentation for satisfaction of return outpatient clinic visits are characterized by CPT codes 99212, 99213, and 99214, based on complexity of the visit and the detail of examination and treatment plan. These oftentimes include a chief complaint, history of present illness, review of systems, an accurate list of medications, physical exam, which includes vitals and a pin score, an assessment and a plan.

In describing the deficiencies in respondent's medical records for Patient C, Dr. Pope stated: "most notes lacked a well-defined chief complaint. None had a review of symptoms." Further, he stated: "The accuracy of the medical chart is uncertain. It appeared that the patient had legacy prescribed medication listed on the active list that did not correlate with those prescribed. Templates are commonly used in medical records. Accuracy between one visit and another are not always performed," and mistakes happen but "not with the regularity of this record."

## **PATIENT C- GROSS NEGLIGENCE**

72. Dr. Pope explained that, in 2012, it was recommended to avoid co-prescribing benzodiazepines, muscle relaxants and opioids because the risk of drug related side effects and complications increase.

In respondent's opinion, he acted within the standard of care when he provided care and treatment for Patient C, and he appropriately prescribed controlled medications to this patient, that he did not excessively prescribe, and that he was able to provide pain relief for her such that she had a better quality of life.

Respondent described the treatment Patient C had received since her injury in 2006. In his opinion, the doses he prescribed were not excessive because they were within the FDA guidelines, and he had not received complaints about his prescribing practices from other physicians who were treating the patient.

Because respondent was erroneously precluded from presenting expert opinion to defend himself on his care and treatment of Patient C, there is insufficient evidence to establish respondent's care and treatment of patient C constituted an extreme departure from the standard of care.

## **PATIENT C- REPEATED NEGLIGENT ACTS**

73. Because respondent was erroneously precluded from presenting expert opinion to defend himself on his care and treatment of Patient C, there is insufficient evidence to establish respondent engaged in repeated negligent acts.

#### **PATIENT C - REPEATED ACTS OF CLEARLY EXCESSIVELY PRESCRIBING**

74. Because respondent was erroneously precluded from presenting expert opinion to defend himself on his care and treatment of Patient C, there is insufficient evidence to establish that respondent committed repeated acts of clearly excessive prescribing drugs or treatment to Patient C.

#### **PATIENT C - FAILURE TO MAINTAIN ADEQUATE AND ACCURATE RECORDS**

75. Because respondent was erroneously precluded from presenting expert opinion to defend himself on his care and treatment of Patient C, there is insufficient evidence to establish that respondent failed to maintain adequate and accurate records in connection with his care and treatment of Patient C.

## Patient D<sup>34</sup>

76. Dr. Pope identified the records that he reviewed and upon which he relied in rendering his opinions regarding respondent's care and treatment of Patient D, including the following:

- Certified copy of Patient D's Medical Examiner's investigation report, autopsy report and toxicology report,
- Certified copy of Patient D's death certificate,
- Certified copy of Patient D's death investigation report from the San Diego Sheriff's Department,
- Certified copy of Patient D's medical records from Sharp Hospital,
- Certified copy of Patient D's medical records from Scripps Mercy Hospital of Chula Vista,
- Certified copy of Patient D's medical records from Sharp Grossmont Hospital,
- Certified copy of Patient D's medical records from respondent's office,
- Respondent's curriculum vitae,

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<sup>34</sup> The letter is used to maintain patient confidentiality.

- Respondent's retention of medical records policy,
- Uncertified copy of Patient D's medical records from respondent's office,
- Certification of Patient D's medical records from respondent's office,
- Transcript of respondent's interview,
- CURES patient report,
- Compact disc with Patient D's medical records from Sharp Grossmont Hospital,
- Certified copy of Patient D's medical records maintained by respondent,<sup>35</sup> and
- Audio of respondent's interview.

77. Between December 2011 and July 2012, respondent provided care and treatment for Patient D's chronic pain.<sup>36</sup> Among other things, she had diagnoses of cervical spondylosis, multiple sclerosis, Cushing's Syndrome, Thoracic Kyphoplasty

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<sup>35</sup> Dr. Pope received medical records from respondent's office on different dates.

<sup>36</sup> Conduct occurring more than seven years from the filing date of the First Amended Accusation involving Patient D is for informational purposes only and is not alleged as a basis for disciplinary action.

(which would suggest a vertebral compression fracture), pulmonary emboli, insulin-dependent diabetes, central pain syndrome and opioid dependence.

On August 1, 2012, Patient D died of a drug overdose while under respondent's care. The medical examiner's autopsy report determined her cause of death was from "acute Tapentadol, Fentanyl and Alprazolam intoxication."

78. During the hearing, respondent admitted that, during the time that Patient D was under the care of respondent, she was morbidly obese; she had a long history of poor pulmonary function and pulmonary disease, and she had a documented history of opioid dependence. Also, respondent admitted that she was opioid dependent and explained, anyone who has been on opioids for more than six months is opioid dependent; however, opioid dependent is distinguished from opioid abuse.

During the time that he treated Patient D, respondent did not have her prior medical records. He was not aware of Patient D's medical history until after the board filed charges against him regarding Patient D. No evidence was offered to the contrary.

79. Dr. Pope reviewed Patient D's medical records for the period between January 5, 2009, and July 30, 2012. He noted that Patient D had a documented history of opioid dependence; Patient D had a long and documented history of multiple emergency department and hospital admissions for various medical conditions, including documentations due to opioid induced respiratory depression. Also, Dr. Pope noted that on November 23, 2011, Patient D visited the emergency department and what occurred during this visit.

During the time that he treated Patient D, respondent did not have her prior medical records. He was not aware of the facts in the foregoing paragraph until after the board filed charges against him regarding Patient D. No evidence was offered to the contrary.

80. On December 23, 2011, respondent had his initial assessment of Patient D. In his chart note for the visit, respondent documented that "[Patient D] had leftover Methadone from a *few years* ago and began taking due to the fact that she was out of Oxy IR ... [Patient D] stated that she last took Methadone this morning."

81. Between December 2011 and July 2012, respondent managed Patient D on many different medication classes for her drug therapy, including but not limited to opioids, benzodiazepines and muscle relaxants at the same time. According to respondent's testimony, supported by the CURES report, Patient D's primary care physician prescribed the benzodiazepine, and he did not.

82. In a chart note for Patient D, dated July 26, 2012, respondent documented that the patient wanted to change medications, namely replace Dilaudid with Nucynta<sup>37</sup> because she reported that Nucynta was more effective for her pain control. Respondent prescribed transdermal Fentanyl 25 mcg patch<sup>38</sup> every 48 hours,

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<sup>37</sup> Pursuant to Health and Safety Code section 11055, subdivision (b), Nucynta is a brand name for Tapentadol, a Schedule II controlled substance; pursuant to Business and Professions Code section 4022, it is a dangerous drug.

<sup>38</sup> Transdermal Fentanyl (Duragesic) patches are applied to the skin; used to relieve severe pain; the patch is usually applied to the skin once every 72 hours. Fentanyl patches may cause serious life-threatening breathing.

Nucynta 100 mg #228, while on Xanax prescribed by her primary care physician. Expert testimony established that this new regimen represented a MME of 395; the transition from Hydromorphone (Dilaudid) to Tapentadol (Nucyntal) represented an MME increase of 152.<sup>39</sup>

83. In Dr. Pope's opinion, respondent's medical records for Patient D were deficient; as he reviewed the medical records Dr. Pope described the deficiencies. Respondent did not document that vital signs were taken at each visit; his review of systems was actually a physical examination, not a review of systems; further, he copied his "review of systems" from each office visit to the next; at times respondent identified a chief complaint but did not chart a clearly defined complaint on a regular basis; finally, the accuracy of the medical chart is uncertain. It appeared that "Patient D had prescribed medications on the active list that did not correlate with those on the prescribed."

In his expert report, Dr. Pope stated "appropriate titration requires an assessment of vital signs." There is no dispute that respondent did not take Patient D's vital signs while under respondent's care.

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<sup>39</sup> Dr. Pope addressed the issue of the increase in MME when respondent replaced Dilaudid with Nucynta in his report but not during his testimony. However, there was some typographical mistakes regarding this issue; for example, there was a reference to Patient A and he referred to transition from Nucynta to Dilaudid; however, he properly cited respondent's chart note for July 26, 2012; therefore, it was presumed that these were typographical mistakes.

Dr. Pope explained that "templates are commonly used in the medical space. Accuracy between one visit and another are not always performed *[sic]* and mistakes do happen, but not to the regularity of this record."

#### **PATIENT D - GROSS NEGLIGENCE**

84. Because respondent was erroneously precluded from presenting expert opinion to defend himself on his care and treatment of Patient D, there is insufficient evidence to establish respondent committed any extreme departure with respect to patient D.

#### **PATIENT D - REPEATED NEGLIGENT ACTS**

85. As there was no evidence that respondent received Patient D's medical records while he provided care and treatment for Patient D, it was not established that respondent engaged in repeated negligent acts when he did not document Patient D's medical hospitalizations

86. Because respondent was erroneously precluded from presenting expert opinion to defend himself on his care and treatment of Patient D, there is insufficient evidence to establish respondent committed repeated acts of clearly excessive prescribing drugs or treatment to Patient D.

#### **PATIENT D - FAILURE TO MAINTAIN ADEQUATE AND ACCURATE RECORDS**

87. Because respondent was erroneously precluded from presenting expert opinion to defend himself on his care and treatment of Patient D, there is insufficient evidence to establish respondent failed to maintain adequate and accurate records in connection with his care and treatment of Patient B.

## **Patient E<sup>40</sup>**

88. Dr. Pope identified the records that he reviewed and upon which he relied in rendering his opinions regarding respondent's care and treatment of Patient E, including the following:

- Certified copy of Patient E's medical examiner's investigative report, autopsy report, and toxicology report,
- Certified copy of Patient E's death certificate,
- Certified copy of the death investigation report from the San Diego County Sheriff's Department,
- Certified copy of Patient E's medical records,
- Respondent's curriculum vitae,
- Respondent's retention of medical records policy,
- Transcription of respondent's interview,
- CURES patient profile report,
- Audio of respondent's interview,
- Certified copy of Patient E's medical records, and

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<sup>40</sup> Letter E is used to maintain patient confidentiality.

- Audio of respondent's interview.

89. Between April 2013 and October 2013, respondent provided pain management for Patient E due to low back pain.<sup>41</sup> On December 15, 2013, Patient E died of a drug overdose. The medical examiner's autopsy report determined his cause of death was from "acute bronchopneumonia, contributing: chronic prescription medication abuse with acute oxycodone and alcohol intoxication; pulmonary emphysema, and hepatic cirrhosis."

90. In a chart note for Patient E, dated June 26, 2013, a UDS drug sample was taken. Respondent obtained the result on July 15, 2013, indicating that the test was inconsistent because Patient E was "negative" for benzodiazepines, despite being prescribed benzodiazepine by respondent.

Expert testimony established that the standard of care required that, under the circumstances, respondent would make sure the validity of the test was appropriate, and the sensitivity was appropriate and then talk to the patient and attempt to dissect out the risk-benefit profile of continuing to do that.

Respondent did not document that he required Patient E to get another UDS and/or other confirmatory screen to confirm that he was taking the controlled medication being prescribed to him. He did not document any discussion with Patient

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<sup>41</sup> Conduct occurring more than seven years from the filing date of the Accusation involving Patient E is for informational purposes only and is not alleged as a basis for disciplinary action.

E in the medical record about any past history of illicit drug use. Instead, respondent continued to issue prescriptions for controlled pain medication.

91. Patient E had a history of illicit drug use. Respondent did not document in the medical record that he had a discussion with Patient E about his past history of illicit drug use.

#### **PATIENT E - REPEATED NEGLIGENT ACTS**

92. Expert testimony established that respondent's failure to require Patient E to get another UDS and/or other confirmatory screen to confirm that Patient E was taking the controlled medications that respondent had been prescribing was a simple departure from the standard of care.

93. Expert testimony established that respondent's failure to document any discussion with Patient E about his past history of illicit drug use was a simple departure from the standard of care.

94. Based on the foregoing (Findings 104, 105, 106, 107 and 108), respondent engaged in repeated negligent acts.

#### **PATIENT E - FAILURE TO MAINTAIN ADEQUATE AND ACCURATE RECORDS**

95. Expert testimony established that respondent failed to maintain adequate and accurate records in connection with his care and treatment of Patient E.

### **Mitigation and Rehabilitation**

96. The board has licensed respondent for more than 30 years. He has practiced as a pain management specialist for more than 25 years. There is no evidence that, prior to the complaints in this case, there has been any other complaint

filed against respondent. Besides a pending civil complaint, there is no evidence that any other civil action had been filed against respondent.

97. Respondent provided the following letters of support as a physician and surgeon: Patient A, two of respondent's employees, two physicians (Sharon Thompson, M.D. and Brenton Wynn, M.D.).

Dr. Thompson described her education, training and experience. After completing her residency, Dr. Thompson participated in a pain management fellowship at Vanderbilt University but did not receive the certification because it was in the anesthesiology department, and her specialty was physical medicine and rehabilitation. She has active licenses in Georgia and California, first licensed in California in 1985.

Dr. Thompson had worked with respondent as a contract physician, most of the time on a part-time basis, most recently, maybe in\_ the last two years on a full-time basis. They are in the midst of negotiating a contract for her to provide services in his practice.

Over the course of time, Dr. Thompson has provided care for the majority of patients in his practice; in her opinion, he is competent, has a good reputation in the community, and she has learned from him.

Dr. Thompson learned about the charges against respondent in early 2019; she read a portion of the

Accusation immediately prior to testifying and believes that the charges are essentially "excessive prescribing."

Dr. Wynn described his education, training and experience. He did a residency in physical medicine and rehabilitation and a fellowship in interventional musculoskeletal medicine. He was first licensed in California in 2003 and has known respondent since 2005 and is familiar with his practice.

Dr. Wynn and respondent have covered for each other, and there have been patients who have gone from Dr. Wynn's practice to respondent's and vice versa, usually because of issues related to insurance. Dr. Wynn has reviewed some of respondent's medical records, the majority on a limited basis.

In Dr. Wynn's opinion, respondent is a competent, ethical and compassionate physician who provides care for complex patients.

Dr. Wynn was not aware of the charges against respondent. He had not reviewed the Accusation or First Amended Accusation. Dr. Wynn stated that, if the charge was related to over prescribing, it would not change his opinion. Further, he stated that, in his opinion, "doing something outside the standard of practice of medicine would be out of character" for respondent. Patient A testified on behalf of respondent. She described the pain relief that he provided and his compassion. As a result, she had increased ability to participate in activities of daily living.

In addition, respondent submitted an additional 17 letters from patients. They support the testimony of Patient A.

### **Other Matters Considered**

98. Respondent did not understand the standard of care regarding the intrathecal pump, specifically the amount of Fentanyl that can be used in the pump, the programming of the pump or the use of intrathecal therapy in conjunction with systemic therapy; most significantly, respondent was treating pain without justification for potential harm to Patient A.

99. Respondent was aware of the CDC's guidelines for excessive MME but nevertheless continued to prescribe excessive doses of MME because he was a pain management specialist or his patient was opioid dependent, again, without regard to the potential dangers to patients.

100. Based on his own testimony, it appeared that respondent was relying on the standard of care between 1990 and 2010, rather than the standard of care between 2011 and 2017. Regarding the intrathecal therapy, respondent explained that he had been filling pumps in the same manner for the prior 25 years, and it had worked. Regarding MME, he explained that between 1990 and 2010, it was drummed into his head [and other pain management specialists] to provide sufficient opioids to relieve pain, and there was no ceiling on prescribing opioids. He had not changed his practice or provided justification for the deviation from the standard of care at the time.

101. Regarding his medical records, respondent admitted that he used templates to complete his medical records but they were frequently inaccurate and confusing. Most significantly, from the medical records, it was difficult to determine whether Patient A had an implanted intrathecal pump between 2010 and 2012.

Frequently, it was difficult to determine what medications had been prescribed for patients.

102. Despite Dr. Thompson's commitment to be honest, it cannot be disregarded that she might have been biased when she testified in this case.

103. No evidence was offered to establish that any of the patients who submitted letters in support of respondent were aware of the charges filed by the board in this case.

104. No evidence was offered to establish that respondent has accepted responsibility or changed his practice.

## **LEGAL CONCLUSIONS**

### **Purpose of Discipline**

1. The purpose of the Medical Practice Act (Chapter I, Division 2, of the Business and Professions Code) is to assure the high quality of medical practice; in other words, to keep unqualified and undesirable persons and those guilty of unprofessional conduct out of the medical profession. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 574.)

The purpose of administrative discipline is not to punish, but to protect the public by eliminating those practitioners who are dishonest, immoral, disreputable or incompetent. (*Fahmy v. Medical Board of California* {1995} 38 Cal.App.4th 810, 817.)

## Relevant Statutes

2. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, be publicly reprimanded which may include a requirement that the licensee complete relevant educational courses, or have such other action taken in relation to discipline as the board deems proper.

3. Section 2234 of the Code states in part:

The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

(b) Gross negligence.

(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

[U] ... [11]

(d) Incompetence ...

4. Unprofessional conduct under section 2234 of the Code is conduct which breaches the rules of ethical conduct of the medical profession, or conduct which is unbecoming of a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 575.)

5. Section 2266 of the Code states:

The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct.

6. Section 725 of the Code states:

(a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon, dentist, podiatrist, psychologist, physical therapist, chiropractor, optometrist, speech-language pathologist or audiologist.

(b) Any person who engages in repeated acts of clearly excessive prescribing or administering of drugs or treatment is guilty of a misdemeanor and shall be punished

by a fine of not less than one hundred dollars (\$100) nor more than six hundred dollars (\$600), or by imprisonment for a term of not less than 60 days nor more than 180 days, or by both that fine and imprisonment.

(c) A practitioner who has a medical basis for prescribing, furnishing, dispensing, or administering dangerous drugs or prescription controlled substances shall not be subject to disciplinary action or prosecution under this section.

(d) No physician and surgeon shall be subject to disciplinary action pursuant to this section for treating intractable pain in compliance with Section 2241.5.

7. Section 4022 of the Code states:

"Dangerous drug" or "dangerous device" means any drug or device unsafe for self-use in humans or animals, and includes the following:

(a) Any drug that bears the legend: "Caution: federal law prohibits dispensing without prescription," "Rx only," or words of similar import.

(b) Any device that bears the statement: "Caution: federal law restricts this device to sale by or on the order of a \_\_," "Rx only," or words of similar import, the blank to be filled in with the designation of the practitioner licensed to use or order use of the device.

(c) Any other drug or device that by federal or state law can be lawfully dispensed only on prescription or furnished pursuant to Section 4006.

## **Relevant Case Law**

8. Medical providers must exercise that degree of skill, knowledge, and care ordinarily possessed and exercised by members of their profession under similar circumstances. (*Powell v. Kleinman* (2007) 151 Cal.App.4th 112, 122.) Because the standard of care is a matter peculiarly within the knowledge of experts, expert testimony is required to prove or disprove that a medical practitioner acted within the standard of care unless negligence is obvious to a layperson. (*Johnson v. Superior Court* (2006) 143 Cal.App.4th 297, 305.)

9. Courts have defined gross negligence as "the want of even scant care or an extreme departure from the ordinary standard of care." (*Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3rd 1040, 1052.) Simple negligence is merely a departure from the standard of care.

In *Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 575, the appellate court noted that "unprofessional conduct" as that term was used in Business and Professions Code section 2361 (now section 2234), included certain enumerated conduct. (Id. at p. 575.) The court further stated (*Ibid*):

This does not mean, however, that an overly broad connotation is to be given the term "unprofessional conduct;" it must relate to conduct which indicates an unfitness to practice medicine. [Citations.] Unprofessional conduct is that conduct which breaches the rules or ethical code of a profession, or conduct which is unbecoming a member in good standing of a profession. [Citation.]

### **Violations, if any**

10. Pursuant to Business and Professions Code section 2234, subdivision (b), cause exists to discipline respondent's Certificate in that he committed gross negligence in his care and treatment of Patient B.

11. Pursuant to Business and Professions Code section 2234, subdivision (c), cause exists to discipline respondent's Certificate in that he engaged in repeated negligent acts in his care and treatment of Patients B, and E.

12. Pursuant to Business and Professions Code section 2234, as defined in Business and Profession Code section 725, cause exists to discipline respondent's Certificate in that he clearly excessively prescribed drugs to Patient B.

13. Pursuant to Business and Professions Code section 2266, cause exists to discipline respondent's Certificate in that respondent failed to maintain adequate and accurate records in connection with his care and treatment of Patients B and E.

14. Pursuant to Business and Professions Code section 2234, cause exists to discipline respondent's Certificate in that respondent engaged in unprofessional conduct in his care and treatment of Patients B and E.

### **Appropriate Measure of Discipline**

15. The purpose of the Medical Practice Act is to assure the high quality of medical practice. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 574.) Conduct supporting the revocation or suspension of a medical license must demonstrate unfitness to practice. The purpose of a disciplinary action is not to punish but to protect the public. In an administrative disciplinary proceeding, the inquiry must be limited to the effect of the doctor's actions upon the quality of his service to his patients. (*Watson v. Superior Court* (2009) 176 Cal.App.4th 1407, 1416.) Because the main purpose of license discipline is to protect the public, patient harm is not required before the board can impose discipline. It is far more desirable to impose discipline on a physician before there is patient harm than after harm has occurred. (*Griffiths v. Superior Court* (2002) 96 Cal.App.4th 757, 772-773).

16. Rehabilitation requires a consideration of those offenses from which one has allegedly been rehabilitated. (*Pacheco v. State Bar* (1987) 43 Cal.3d 1041, 1048.) Rehabilitation is a state of mind, and the law looks with favor upon rewarding with the

opportunity to serve one who has achieved reformation and regeneration. (*Id.* at 1058.) The absence of a prior disciplinary record is a mitigating factor. (*Chefsky v. State Bar* (1984) 36 Cal.3d 116, 132, fn. 10.) Remorse and cooperation are mitigating factors. (*In re Demergian* (1989) 48 Cal.3d 284, 296.) While a candid admission of misconduct and full acknowledgment of wrongdoing may be a necessary step in the rehabilitation process, it is only a first step. A truer indication of rehabilitation is presented if an individual demonstrates by sustained conduct over an extended period of time that he is once again fit to practice. (*In re Trebilcock* (1981) 30 Cal.3d 312, 315-3J6.)

17. In making a determination about the appropriate level of discipline, the highest priority is protection of the public from harm.

Respondent had been licensed by the board more than 30 years, with no prior disciplinary action, no prior complaints and one pending civil action. The testimony and letters in support of respondent were considered. However, this case involved numerous violations of the Medical Practice Act in respondent's care and treatment of five patients.

With the exception of acknowledging that the information that he included on the "excel sheet" could not be programmed into the pump, at no time did respondent acknowledge that he made a mistake; though he changed his practice by reprogramming the pumps in his practice, respondent did so because of the issues associated with the board filing the pleadings in this case, not because it was wrong or below the standard of care.

Of greatest concern was respondent's failure/refusal to understand the standard of care for programming the intrathecal pump, his failure/refusal to understand the significance of excessively prescribing Fentanyl, failure/refusal to acknowledge the

danger associated with intrathecal and systemic drug therapy, failure to understand the dangers of excessively prescribing MME, not explaining his significant deviations from the standard of care in medical records and failing to maintain adequate and accurate records and attempting to justify his deficient records.

There is no evidence that respondent accepted responsibility for his mistakes or that he had taken action to change/correct his practice. Given the facts and the law, in order to adequately protect the public, the following order is made.

## **ORDER**

Physician and Surgeon's Certificate No. G 66777 issued to David James Smith, M.D., is revoked. However, the revocation is stayed, and he is placed on probation for five years, retroactive to September 24, 2020, with the following terms and conditions; respondent is to receive full credit for all periods of probation already served and any term of probation already satisfied before the Superior Court remanded this matter back to the Board.<sup>1</sup>

### **1. Controlled Substances - Maintain Records and Access to Records and Inventories**

Respondent shall maintain a record of all controlled substances ordered, prescribed, dispensed/ administered, or possessed by respondent, and any recommendation or approval which enables a patient or patient's primary caregiver to possess or cultivate marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5, during probation; showing all of the following: (1) the name and address of patient; (2) the date; (3) the character and quantity of controlled substances involved; and (4) the indications and diagnosis for which the controlled substances were furnished.

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<sup>1</sup> Respondent shall be entitled to petition for termination or modification of probation consistent with Business and Professions Code, section 2307, commencing with the effective date of this probation, i.e., September 24, 2020.

Respondent shall keep these records in a separate file or ledger, in chronological order. All records and any inventories of controlled substances shall be available for immediate inspection and copying on the premises by the board or its designee at all times during business hours and shall be retained for the term of probation.

## **2. Education Course**

Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, respondent shall submit to the board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of his license. Following completion of each course, the board or its designee may administer an examination to test respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

## **3. Prescribing Practices Course**

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a course in prescribing practices approved in advance by the board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six months after respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one year of

enrollment. The prescribing practices course shall be at respondent's expense and shall be in addition to the CME requirements for renewal of his license.

A prescribing practices course taken after the acts that gave rise to the charges in the First Amended Accusation, but prior to the effective date of the Decision may, in the sole discretion of the board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

#### **4. Medical Record Keeping Course**

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a medical record keeping course, approved in advance by the board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six months after respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one year of enrollment. The medical record keeping course shall be at respondent's expense and shall be in addition to the CME requirements for renewal of his license.

A medical record keeping course taken after the acts that gave rise to the charges in the First Amended Accusation, but prior to the effective date of the Decision may, in the sole discretion of the board or its designee, be accepted towards

the fulfillment of this condition if the course would have been approved by the board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

#### **5. Professionalism Program (Ethics Course)**

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a professionalism program, that meets the requirements of Title 16, California Code of Regulations (CCR) section 1358.1. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six months after respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one year after attending the classroom component. The professionalism program shall be at respondent's expense and shall be in addition to the CME requirements for renewal of his license.

A professionalism program taken after the acts that gave rise to the charges in the First Amended Accusation, but prior to the effective date of the Decision may, in the sole discretion of the board or its designee, be accepted towards the fulfillment of this condition if the program would have been approved by the board or its designee had the program been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the board or its designee not later than 15 calendar days after successfully completing the program or not later than 15 calendar days after the effective date of this Decision, whichever is later.

## **6. Clinical Competence Assessment Program**

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a clinical competence assessment program approved in advance by the board or its designee. Respondent shall successfully complete the program not later than six months after respondent's initial enrollment unless the board or its designee agrees in writing to an extension of that time.

The program shall consist of a comprehensive assessment of respondent's physical and mental health and the six general domains of clinical competence as defined by the Accreditation Council on Graduate Medical Education and American Board of Medical Specialties pertaining to respondent's current or intended area of practice. The program shall take into account data obtained from the pre-assessment, self-report forms and interview, and the Decision, First Amended Accusation, and any other information that the board or its designee deems relevant. The program shall require respondent's on-site participation for a minimum of three and no more than five days as determined by the program for the assessment and clinical education evaluation. Respondent shall pay all expenses associated with the clinical competence assessment program.

At the end of the evaluation, the program will submit a report to the board or its designee which unequivocally states whether respondent has demonstrated the ability to practice safely and independently. Based on respondent's performance on

the clinical competence assessment, the program will advise the board or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, evaluation or treatment for any medical condition or psychological condition, or anything else affecting respondent's practice of medicine. Respondent shall comply with the program's recommendations.

Determination as to whether respondent successfully completed the clinical competence assessment program is solely within the program's jurisdiction.

If respondent fails to enroll, participate in, or successfully complete the clinical competence assessment program within the designated time period, respondent shall receive a notification from the board or its designee to cease the practice of medicine within three calendar days after being so notified. Respondent shall not resume the practice of medicine until enrollment or participation in the outstanding portions of the clinical competence assessment program have been completed. If respondent does not successfully complete the clinical competence assessment program, respondent shall not resume the practice of medicine until a final decision has been rendered on the Accusation and/or a Petition to Revoke Probation. The cessation of practice shall not apply to the reduction of the probationary time period.

Respondent shall not order, prescribe, dispense, administer, furnish or possess Schedule II, III, or IV drugs until after proof of successful completion of the Clinical Competence Assessment Program has been provided to the board.

Respondent is prohibited from performing any care or treatment with patients involving the use, management or any surgical procedures related to intrathecal pumps until after successful completion of Clinical Competence Assessment Program has been provided to the board.

## **7. Monitoring - Practice**

Within 30 calendar days of the effective date of this Decision, respondent shall submit to the board or its designee for prior approval as a practice monitor, the name, and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the board, including but not limited to any form of bartering, shall be in respondent's field of practice, and must agree to serve as respondent's monitor.

Respondent shall pay all monitoring costs.

The board or its designee shall provide the approved monitor with copies of the Decision and First Amended Accusation, and a proposed monitoring plan. Within 15 calendar days of receipt of the \_Decision, First Amended Accusation, and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision and First Amended Accusation, fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the board or its designee.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the term of probation.

If respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, respondent shall receive a notification from the board or its designee to cease the practice of medicine within three calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor(s) shall submit a quarterly written report to the board or its designee which includes an evaluation of respondent's performance, indicating whether respondent's practices are within the standards of practice of medicine, and whether respondent is practicing medicine safely. It shall be the sole responsibility of respondent to ensure that the monitor submits the quarterly written reports to the board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, within 5 calendar days of such resignation or unavailability, respondent shall submit to the board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, respondent shall receive a notification from the board or its designee to cease the practice of medicine within three calendar days after being so notified. Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, respondent may participate in a professional enhancement program approved in advance by the board or its designee, that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at respondent's expense during the term of probation.

## **8. Supervision of Physician Assistants and Advanced Practice Nurses**

During probation, respondent is prohibited from supervising physician assistants and advanced practice nurses.

## **9. Notification**

Within seven days of the effective date of this Decision, respondent shall provide a true and correct copy of this Decision and First Amended Accusation to the chief of staff or the chief executive officer at every hospital where privileges or membership are extended to him, at any other facility where respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the chief executive officer at every insurance carrier which extends malpractice insurance coverage to him. Respondent shall provide proof of compliance to the board or its designee within 15 calendar days of the effective date of this Decision.

## **10. Obey All Laws**

Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and shall remain in full compliance with any court ordered criminal probation, payments, and other orders.

## **11. Quarterly Declarations**

Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

## **12. General Probation Requirements**

Respondent shall comply with the board's probation unit.

At all times, Respondent shall keep the board informed of his business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021, subdivision (b).

Respondent shall not engage in the practice of medicine in respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

Respondent shall maintain a current and renewed California physician's and surgeon's license.

Respondent shall immediately inform the board or its designee in writing of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than 30 calendar days.

In the event respondent should leave the State of California to reside or to practice respondent shall notify the board or its designee in writing 30 calendar days prior to the dates of departure and return.

## **13. Interview with the Board or its Designee**

Respondent shall be available in person upon request for interviews either at respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

#### **14. Non-practice While on Probation**

Respondent shall notify the board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of respondent's return to practice. Non-practice is defined as any period of time respondent is not practicing medicine, as defined in Business and Professions Code sections 2051 and 2052, for at least 40 hours in a calendar month, in direct patient care, clinical activity or teaching, or other activity as approved by the board. If respondent resides in California and is considered to be in non-practice, respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the board or its designee shall not be considered non-practice and does not relieve respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event respondent's period of non-practice while on probation exceeds 18 calendar months, respondent shall successfully complete the Federation of State Medical Board's Special Purpose Examination, or, at the board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice for respondent, residing outside of California, will relieve respondent of the responsibility to comply with the probationary terms and

conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws, General Probation Requirements, and Quarterly Declarations.

**15. Completion of Probation**

Respondent shall comply with all financial obligations (e.g., payment of educational courses, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, respondent's certificate shall be fully restored.

**16. Violation of Probation**

Failure to fully comply with any term or condition of probation is a violation of probation. If respondent violates probation in any respect, after giving notice and the opportunity to be heard, the board may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against respondent during probation, the board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

**17. License Surrender**

Following the effective date of this Decision, if respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may request to surrender his license. The board reserves the right to evaluate respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, within 15 calendar days, respondent shall deliver his wallet and wall certificate to the board or its designee, and respondent shall no longer practice

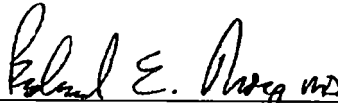
medicine. Respondent shall no longer be subject to the terms and conditions of probation. If respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

**18. Probation Monitoring Costs**

Respondent shall pay the costs associated with probation monitoring every year of probation, as designated by the board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the board or its designee no later than January 31 of each calendar year.

This Decision is retroactively effective to September 24, 2020 .

IT IS SO ORDERED this 11 day of August 2022.

  
\_\_\_\_\_  
Richard E. Thorp, M.D., Chair  
MEDICAL BOARD OF CALIFORNIA  
Panel B